Washington

UNIFORM APPLICATION
FY 2009 - STATE PLAN

COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 08/06/2008 - Expires 08/31/2011

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Center for Mental Health Services
Division of State and Community Systems Development

Introduction:

The CMHS Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, parts XI and IV, respectively).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0168.

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Washington

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FACE SHEET

FISCAL YEAR/S COVERED BY THE PLAN

_X_ FY2009 ___ FY 2009-2010 ___ FY 2009-2011

STATE NAME: Washington

DUNS #: 12-734-7115

I. AGENCY TO RECEIVE GRANT

AGENCY: Department of Social and Health Service

ORGANIZATIONAL UNIT: Mental Health Division

STREET ADDRESS: PO Box 45320

CITY: Olympia STATE: WA ZIP: 98504-0809

TELEPHONE: 360-902-0843 FAX: 360-902-0809

II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT

NAME: Richard E. Kellogg TITLE: Director

AGENCY: Department of Social and Health Division

ORGANIZATIONAL UNIT: Mental Health Division

STREET ADDRESS: PO Box 45320

CITY: Olympia STATE: WA ZIP CODE: 98504-5320

TELEPHONE: (360) 902-0790 FAX: (360) 902-0809

III. STATE FISCAL YEAR

FROM: 07/01/2008 TO: 06/30/2009

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

NAME: Judy Gosney TITLE: Mental Health Program Administrator

AGENCY: Department of Social and Health Division

ORGANIZATIONAL UNIT: Mental Health Division

STREET ADDRESS: PO Box 45320

CITY: Olympia STATE: WA ZIP: 98504-5320

TELEPHONE: 360-902-0827 FAX: 360-902-0809 EMAIL: gosneja@DSHS.WA.gov

Washington

Executive Summary

Please respond by writing an Executive Summary of your current year's application.

The Mental Health Division (MHD) of the State of Washington is pleased to submit its application and plan for the utilization of Community Mental Health Services Block Grant funding for FFY 2009. This plan meets all of the requirements of the application, and has been reviewed by community stakeholders, is supported by the state Mental Health Planning and Advisory Council (MHPAC). The plan is aimed at achieving the following:

þÿ "Increasing access to a comprehensive system of care, including employment, housing, case management, rehabilitation, dental and health services, along with mental health services and supports;
þÿ "Ensuring the participation of consumers and their families in planning and evaluation of state systems;
þÿ "Improving access for underserved populations, including older adults, homeless people and rural populations;
þÿ "Expanding the promotion of recovery and community integration of people with psychiatric disabilities; and
þÿ "Delivering accountability through uniform reporting on access, quality, and the outcome of services.

In tandem with the federal guidelines, this document encompasses Washington
þÿ S t a t e s c o m m i t m e n t t o t h e g o a l s o u t l i n e d
þÿ N e w F r e e d o m C o m m i s s i o n o n M e n t a l H e a l t h
þÿ T r a n s f o r m i n g M e n t a l H e a l t h C a r e i n A m e r i

þÿ "Americans understand that mental health is essential to overall health.
þÿ "Mental health care is consumer and family driven.
þÿ "Disparities in mental health services are eliminated.
þÿ "Early mental health screening, assessment, and referral to services are common practice.
þÿ "Excellent mental health care is delivered and research is accelerated.
þÿ "Technology is used to access mental health care and information.

The New Freedom goals remain integrated with the goals of the Mental Health
þÿ P l a n n i n g a n d A d v i s o r y C o u n c i l a n d a d d r e s
þÿ S t r a t e g i c P l a n w h i c h s e r v e s a s t h e p l a t f
achieve transformation.

MHD and its Contractors are continually searching for system improvements; improved access to services that meet individual needs, family and natural supports are utilized, and that community partnerships are strengthened.

Under the guidance of Governor Christine O. Gregoire, Washington is demonstrating a firm commitment to all residents, both in policy and in practice, by dedicating the necessary resources, expertise, and visionary leadership toward a future where transformation of the public mental health system becomes reality.

The MHD continues to focus on the unmet needs described in the adult and child plans and move forward with the plans to implement as system to address these needs. For both populations, the needs are large and the service deliverables will take a period of time to develop. Activities include:

System transformation initiative requirements for employment, housing, benefit redesign and a review of the Involuntary Treatment Act and inpatient utilization management continue.

Collaborative work continues with the all Tribes in the state of Washington, including mental health workgroup meetings and Roundtable meetings to discuss planning for major undertakings of system change.

The ongoing funding for two (2) evidence based-pilot-programs both amended to allow for children to remain in their parent's custody while receiving

out-of-home care and the funding for the Children's Mental Health Act creating three WrapAround pilot sites.

Mental Health Clubhouses also were part of the 2007 legislative focus. Washington Administrative Code (WAC) has been established providing guidelines for certification.

The State of Washington is facing a budget shortfall and has at the time of this writing a freeze on hiring, travel (both in and out-of-state) and contracting. However, the mental health system in the State is moving forward in creating quality care for the consumers of services across the lifespan.

Attachment A

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS

FISCAL YEAR 2009

I hereby certify that Washington agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

Section 1911:

Subject to Section 1916, the State[1] will expend the grant only for the purpose of:

i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:

ii. Evaluating programs and services carried out under the plan; and

iii. Planning, administration, and educational activities related to providing services under the plan.

Section 1912

(c)(1)& (2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms adults with a serious mental illness and children with a severe emotional disturbance and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2008, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

21. The term State shall hereafter be understood to include Territories.

(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a service area)
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.
(b) The duties of the Council are:
(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:

(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;

(2) to make cash payments to intended recipients of health services;

(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or

(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]

(c) The State will:

(1) make copies of the reports and audits described in this section available for public inspection within the State; and
(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

Section 1943:

(a) The State will:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

_____ _____

Governor Date
Christine O. Gregoire, Governor

OMB Approval No. 0920-0428

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub- grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about--
  (1) The dangers of drug abuse in the workplace;
  (2) The grantee's policy of maintaining a drug-free workplace;
  (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
  (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  (1) Abide by the terms of the statement; and
  (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--
  (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
  (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical an mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
APPLICANT ORGANIZATION	DATE SUBMITTED

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. **Type of Federal Action:**	2. **Status of Federal Action**	3. **Report Type:**
☐ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	☐ a. bid/offer/application b. initial award c. post-award	☐ a. initial filing b. material change **For Material Change Only:** Year _____ Quarter _____ date of last report _____

4. **Name and Address of Reporting Entity:**	5. **If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:**
Prime Subawardee Tier _____ , *if known:* **Congressional District**, *if known:*	**Congressional District,** *if known:*
6. Federal Department/Agency:	7. **Federal Program Name/Description:** **CFDA Number**, *if applicable:* _____
8. **Federal Action Number,** *if known:*	9. **Award Amount,** *if known:* **$**
10. a. Name and Address of Lobbying Entity *(if individual, last name, first name, MI):*	b. **Individuals Performing Services** *(including address if different from No. 10a.)* *(last name, first name, MI):*
11. **Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.**	**Signature:** _____ **Print Name:** _____ **Title:** _____ **Telephone No.:** _____ **Date:** _____
Federal Use Only:	Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks "subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., ''RFP-DE-90-001.''

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in con-struction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, re- gulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
APPLICANT ORGANIZATION	DATE SUBMITTED

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Washington

Public Comments on State Plan

Section 1941 of the Block Grant legislation stipulates that as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State Plan. States will make the mental health plan public in such a manner to facilitate comment from any person (including Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

States should describe their efforts and procedures to obtain public comment on the plan on the plan in this section.

þÿ C o m m e n t s a n d f e e d b a c k o n W a s h i n g t o n s M H
a variety of ways. The following is a sample:

þÿ "When the Regional Support Networks (RSN) submit their proposed plan, it is required that it be reviewed by their Advisory Board for community input.
þÿ "Regional Support Network plans were reviewed by the MHPAC at their May and June meetings to allow time for them to provide feedback to the RSNs prior to the July plan review. MHPAC were also invited to join with MHD staff in their review.
þÿ " The Mental Health Division formally distributed the Mental Health Block Grant plan for public review during the month of August 2008.
þÿ "In addition, the MHBG Plan is posted on the internet, inviting comment all year long.

As we did last year, MHD reviewed the input gathered by the outside consultants through their stakeholder work in 2007 on the System Transformation Initiative. During this project they conducted nine (9) separate focus groups and meet with many individuals. MHD also reviewed the input of the community to the Transformation Grant in 2006 when drafting this plan to further coordinate the efforts of that work. The combination of this information is still vital input for planning purposes.

II. SET-ASIDE FOR CHILDREN'S MENTAL HEALTH SERVICES REPORT

States are required to provide systems of integrated services for children with serious emotional disturbances(SED). Each year the State shall expend not less than the calculated amount for FY 1994.

Data Reported by:

State FY __X__ **Federal FY _____**

State Expenditures for Mental Health Services

Calculated FY 1994	Actual FY 2007	Estimate/Actual FY 2008
$17,688,942	$35,526,070	$37,321,827

Waiver of Children's Mental Health Services

If there is a shortfall in children's mental health services, the state may request a waiver. A waiver may be granted if the Secretary determines that the State is providing an adequate level of comprehensive community mental health services for children with serious emotional disturbance as indicated by a comparison of the number of such children for which such services are sought with the availability of services within the State. The Secretary shall approve or deny the request for a waiver not later than 120 days after the request is made. A waiver granted by the Secretary shall be applicable only for the fiscal year in question.

III. MAINTENANCE OF EFFORT(MOE) REPORT

States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory MOE requirements. MOE information is necessary to document that the State has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

MOE Exclusion

The Secretary may exclude from the aggregate amount any State funds appropriated to the principle agency for authorized activities of a non-recurring nature and for a specific purpose. States must consider the following in order to request an exclusion from the MOE requirements:

1. The State shall request the exclusion separately from the application;
2. The request shall be signed by the State's Chief Executive Officer or by an individual authorized to apply for CMHS Block Grant on behalf of the Chief Executive Officer;
3. The State shall provide documentation that supports its position that the funds were appropriated by the State legislature for authorized activities which are of a non-recurring nature and for a specific purpose; indicates the length of time the project is expected to last in years and months; and affirms that these expenditures would be in addition to funds needed to otherwise meet the State's maintenance of effort requirement for the year for which it is applying for exclusion.

The State may not exclude funds from the MOE calculation until such time as the Administrator of SAMHSA has approved in writing the State's request for exclusion.

States are required to submit State expenditures in the following format:

MOE information reported by:

State FY __X__ **Federal FY _____**

State Expenditures for Mental Health Services

Actual FY 2006	Actual FY 2007	Actual/Estimate FY 2008
$237,930,763	$236,727,429	$274,739,059

MOE Shortfalls

States are expected to meet the MOE requirement. If they do not meet the MOE requirement, the legislation permits relief, based on the recognition that extenuating circumstances may explain the shortfall. These conditions are described below.

(1). Waiver for Extraordinary Economic Conditions

A State may request a waiver to the MOE requirement if it can be demonstrated that the MOE deficiency was the result of extraordinary economic conditions that occurred during the SFY in question. An extraordinary economic condition is defined as a financial crisis in which the total tax revenues declined at least one and one-half percent, and either the unemployment increases by at least one percentage point, or employment declines by at least one and one-half percent. In order to demonstrate that such conditions existed, the State must provide data and reports generated by the State's management information system and/or the State's accounting system.

(2). Material Compliance

If the State is unable to meet the requirements for a waiver under extraordinary economic conditions, the authorizing legislation does permit the Secretary, under certain circumstances, to make a finding that even though there was a shortfall on the MOE, the State maintained material compliance with the MOE requirement for the fiscal year in question. Therefore, the State is given an opportunity to submit information that might lead to a finding of material compliance. The relevant factors that SAMHSA considers in making a recommendation to the Secretary include: 1) whether the State maintained service levels, 2) the State's mental health expenditure history, and 3) the State's future commitment to funding mental health services.

TABLE 1. List of Planning Council Members

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Adair, Traci	State Employees	Social Services	P.O. Box 45600 Olympia,WA 98504-5600 PH:(360) 725-2455 FAX:	AdairT@dshs.wa.gov
Alston, Thressa	Others(not state employees or providers)	Ethinic Minority Subcommittee	20454 104th Ave SE Kent,WA 98031 PH:(253) 859-5309 FAX:	talston@highline.edu
Bates, Rebecca	Family Members of Children with SED		525 W 2nd Ave Spokane,WA 99201 PH:(509) 892-9241 FAX:	bbates@voaspokane.org
Bauer, Roger	Providers		PO Box 3208 Omak,WA 98841 PH:(509) 826-8420 FAX:	rbauer@okbhc.org
Benjamin, Charles	Providers	Regional Support Networks	North Sound Regional Support Network 117 N. 1st. Street, Suite # 8 Mt. Vernon,WA 98273 PH:(360) 416-7013 * 39 FAX:	Charles_Benjamin@nsmha.org
Clement, Dan	Providers	Emergency Service Center	1216 20th Avenue East Seattle,WA 98112 PH:(206) 621-7027 FAX:	dclement@desc.org

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Collison, Fran	State Employees	Mental Health	Olympia,WA 98504-5320 PH:(360) 902-0864 FAX:	collifk@dshs.wa.gov
Conant, Annie	State Employees	Housing	906 Columbia St. SW Olympia, WA,WA 98504-2525 PH:(360) 725-2919 FAX:	AnnieC@cted.wa.gov
Cooper, B.J.	Consumers/Survivors/Ex-patients(C/S/X)		2216 Sand Canyon Rd Chewelah,WA 99109 PH:(509) 935-0564 FAX:	nhbills05@yahoo.com
Critchlow, Brien	Consumers/Survivors/Ex-patients(C/S/X)		507 East 131st Street, Lot C Tacoma,WA 98445 PH:(253) 301-0579 FAX:	critchlowb01@comcast.net
Crozier, Rick	Providers	Good Samaritan Behavioral Health-older adult program	325 E Pioneer Ave Puyallup,WA 98372 PH:(253) 697-8547 FAX:	rickcrozier@goodsamhealth.org
Dolezal, Cheri	Family Members of adults with SMI		12505 NE 6th Court Vancouver,WA 98685 PH:(360) 546-0968 FAX:	Cheri.Cdolezal@comcast.net

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Eng, Danny	State Employees	Vocational Rehabilitation	14360 SW Eastgate Way N 40-3 Bellevue,WA 98007 PH:(425) 649-4235 FAX:	Engd@dshs.wa.gov
Furze, John	Consumers/Survivors/Ex-patients(C/S/X)		1418 NE 109th Ave Vancouver,WA 98664 PH:(360) 695-1325 FAX:	johnf@chs-wa.org
Hammond, Russ	State Employees	Education	PO Box 47200 Olympia,WA 98504 PH:(360) 725-6075 FAX:	Russell.Hammond@k12.wa.us
Higgins, Alex	Consumers/Survivors/Ex-patients(C/S/X)		5303 South Alaska Seattle,WA 98118 PH: FAX:	alexhiggins@gmail.com
Johnson, Tamara	Consumers/Survivors/Ex-patients(C/S/X)	Youth 'N Action	,WA PH:(253) 880-4339 FAX:	YouthNActionTamara@yahoo.com
Kehl, Merja	State Employees	Social Services	MS 45710 Olympia,WA 98504-5710 PH:(360)902-0222 FAX:	KHMR300@dshs.wa.gov

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Lewis, Vanessa	Family Members of Children with SED		6486 19th Street W #B Fircrest,WA 98466 PH:(253) 565-2266 FAX:	vlewis@washingtonpave.com
McBride, Kelli	Family Members of Children with SED		3201-30th Ave W Seattle,WA 99199 PH:(206)282-4541 FAX:	kellimcb@hotmail.com
McClain, Dwight	Consumers/Survivors/Ex-patients(C/S/X)		2022 S Woodlawn RD Spokane Valley, WA,WA 99216 PH:(509) 928-9695 FAX:	dwightmcclain@comcast.net
Nash, Cathii	Family Members of Children with SED		3908 East 17th Spokane,WA 99223 PH:(509) 536-4136 FAX:	cathiin@netzero.com
Nichols, Don	Consumers/Survivors/Ex-patients(C/S/X)		PO Box 2974 Walla Walla,WA 99362 PH:(509) 529-7974 FAX:	brothersparkydn@yahoo.com
Nilon, Helen	Consumers/Survivors/Ex-patients(C/S/X)		1220 SW 132nd Lane Apt 513 Burien,WA 98146 PH:(206) 617-7820 FAX:	thenilongroup@comcast.net

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Owen, Eleanor	Family Members of adults with SMI		906 East Shelby Seattle,WA 98102 PH:(206) 322-0408 FAX:	eleanor_owen@mindspring.com
Paulson, Michael	State Employees	Medicaid	P.O. Box 45530 Olympia,WA 98504-5530 PH:(360) 725-1641 FAX:	paulsmj@dshs.wa.gov
Saltrup, Tom	State Employees	Criminal Justice	PO Box 41123 Olympia,WA 98504-1126 PH:(360) 725-8692 FAX:	tesaltrup@DOC1.wa.gov
San Jule, Jill	State Employees	Mental Health	PO Box 45321 Olympia, WA,WA 98504-5321 PH:(360) 902-0821 FAX:	sanjujm@dshs.wa.gov
Trueblood, Dorothy	Family Members of Children with SED		6031 S. Warner Tacoma,WA WA PH:(253)472-1442 FAX:	
Warden, Lenora	Consumers/Survivors/Ex-patients(C/S/X)		701 Commerce St, Apt 208 Tacoma,WA 98402 PH:(253) 272-1845 FAX:	noralynn57@yahoo.com

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Waters, Bill	Others(not state employees or providers)	Washington State Clubhouse Coalition	Val Ogden Center 10201 NE 4th Plain Road Vancouver,WA 98662 PH:(360) 253-4036 FAX:	watersb@valogdencenter.org
Woodrow, JoEllen	Consumers/Survivors/Ex-patients(C/S/X)		1818 West Northridge Court #205 Spokane,WA 99208 PH:509-325-7828 FAX:	gem2005us@yahoo.com

TABLE 2. Planning Council Composition by Type of Member

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	32	
Consumers/Survivors/Ex-patients(C/S/X)	10	
Family Members of Children with SED	5	
Family Members of adults with SMI	2	
Vacancies(C/S/X and Family Members)	0	
Others(not state employees or providers)	2	
TOTAL C/S/X, Family Members and Others	19	59.38%
State Employees	9	
Providers	4	
Vacancies	0	
TOTAL State Employees and Providers	13	40.63%

Note: 1) The ratio of parents of children with SED to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council, 2) State Employee and Provider members shall not exceed 50% of the total members of the Planning Council, and 3) Other representatives may include public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services. 4) Totals and Percentages do not include vacancies.

Washington

Planning Council Charge, Role and Activities

State Mental Health Planning Councils are required to perform certain duties. If available, a charter or a narrative summarizing the duties of the Planning Council should be included. This section should also specify the policies and procedures for the selection of council members, their terms, the conduct of meetings, and a report of the Planning Council's efforts and related duties as mandated by law:

reviewing plans and submitting to the State any recommendations for modification
serving as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems,
monitoring, reviewing, and evaluating, not less than once each year, the allocation and adequacy of mental health services within the State.
the role of the Planning Council in improving mental health services within the State.
<STRONG>In addition to the duties mandated by law, States should include a brief description of the role of the Planning Council in the State's transformation activities that are described in Part C, Section II and Section III. </STRONG>

Membership Requirements

The Washington State Mental Health Planning and Advisory Council (MHPAC - also referred to as "the Planning Council") and its subcommittees operate under Public Law 102-321 and meet all of the MHPAC requirements set forth therein and by this grant. The MHPAC is comprised of >51% consumers, family members, and advocates, with the remaining members meeting and exceeding the requirement for state and other representation from Social Services, Housing, Vocational Rehabilitation, Department of Corrections, Office of Superintendent of Public Instruction, Children's Administration, and advocates for the homeless population, older adults, and ethnic Minorities.

State Mental Health Planning and Advisory Council Membership List

Planning Council Composition by Type of Member:

NOTE: (The table below will self-populate based upon the information that is cut and pasted into web-application from the above roster. Numbers below are from last year's plan- this is just a place holder. The Council membership composition for consumers/family members remains significantly greater than the requisite 50%).

Type of Membership	Number	% of Total
Consumers	8	
Family members of Children with SED	3	
Family members of Adults with SMI	2	
Others: not state employees or providers	3	
Vacancies	1	
TOTAL (consumer, family, and others minus vacancies)	17	56%
State Employees	9	
Providers	5	
Vacancies	0	
TOTAL (State Employees and Providers minus vacancies)	14	44%

The Planning Council has successfully made an impact into the plan for 2009. They met early on with the state planner to get a better understanding of the timelines required for drafting this document. As 80% of the funds are allocated to the Regional Support Networks (RSN) it became apparent to the Council members that to have the greatest impact, they would need to meet early in the new year with the RSN Administrators and the Chair of each RSN's Advisory Board. The Chair of the Council discussed the idea with the Mental Health Division's Director and he gave his support to move forward with the Council's plan to discuss with the RSNs their vision of transformation and use of these funds. The Council discussed with the RSNs present that they would be developing a scoring mechanism by which their plans would be reviewed. While this meeting was not well attended by the RSNs, the message of change was. The RSN plans are due to the MHD May 1st of each year and reviewed by the MHPAC at their May and June meetings. The following is an excerpt from the review by the MHPAC and its' subcommittees of the twelve RSN plans.

"The good news is that more than a couple pockets of innovative miracles were found. I would like to note them here: North Central is funding a mental health professional to be at a health clinic two days per week and hopes to see 150 clients. North Sound will be spending part of its FBG with non-Medicaid children in school, which will allow the schools to directly contract with the MHP on a fee-for-service basis. Peninsula RSN will be funding an Ombuds for non-Medicaid persons. Pierce's HEROS program will be 'tweaking' the Gatekeeper program to include home visits by therapists and peer counselors. Flex funds for medication and housing assistance were proposed by Gray's Harbor, Peninsula, Timberlands, and Thurston-Mason. North Central will be writing MOU's with local law enforcement to reduce JRA convictions. Clark County will be spending nearly 50% of its FBG on a consumer-run program. Thurston-Mason will be funding a free mental health clinic. All great programs – exhibiting out-of-the-box thinking! We wish them well!"

The Council has accomplished many things this year and in 2009 MHD expects that they will continue to focus on transformational activities, be active in Legislative review, participation on a variety of stakeholder committees bring their expertise to the planning and policy level.

Washington
Planning Council Charge, Role and Activities

State Mental Health Planning Councils are required to perform certain duties. If available, a charter or a narrative summarizing the duties of the Planning Council should be included. This section should also specify the policies and procedures for the selection of council members, their terms, the conduct of meetings, and a report of the Planning Council's efforts and related duties as mandated by law: reviewing plans and submitting to the State any recommendations for modification serving as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems, monitoring, reviewing, and evaluating, not less than once each year, the allocation and adequacy of mental health services within the State. The role of the Planning Council in improving mental health services within the State. In addition to the duties mandated by law, States should include a brief description of the role of the Planning Council in the State's transformation activities that are described in Part C, Section II and Section III.

The Mental Health Planning and Advisory Council established the following Vision, Mission and Goals to guide the work of the council:

VISION:

Plan, Advocate, Evaluate

MISSION:

To advocate for a system that supports persons impacted by mental disorders on their journeys to achieve the highest quality of life possible by promoting evidence-based, cost-effective, individualized mental health services.

GOALS:

The Goals of the Mental Health Planning and Advisory Council shall be to transform the mental health system consistent with the goals of the President's New Freedom Commission on Mental Health, as follows:
Primary Goals:

1. Washington State residents acknowledge that mental health is essential to overall health.
2. Mental health care is consumer and family driven.

3. Disparities in mental health services are eliminated.
4. Early mental health screening, assessment and referral to services are common practice.
5. Excellent mental health care is delivered and research is accelerated.
6. Technology is used to access mental healthcare and information

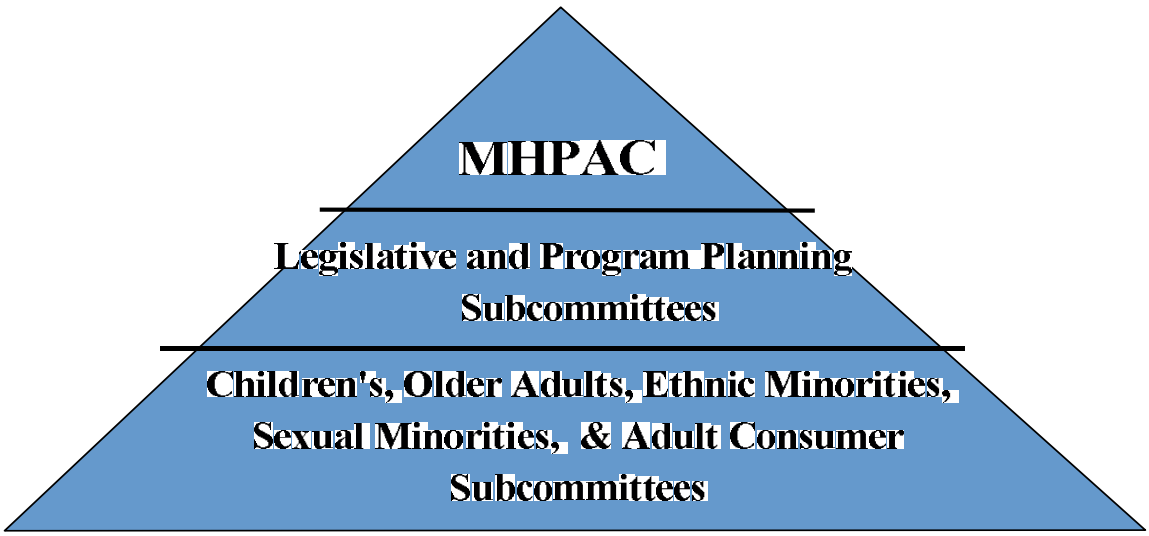
Other Goals:

1. Oversee the Federal Block Grant, including recommending the plan, amendments and reports submitted by the Mental Health Division to the Center for Medicaid and Medicare Services.
2. Develop and take advocacy positions concerning legislation, funding and regulations affecting mental health services through the use of mental health statistics for decision making and planning.
3. Support and advocate for quality, cost effective and individualized consumer/family based services through evidence based best practice models of care. Support research and use of promising practices through continuous quality improvement.
4. Promote optimal functioning for consumers across the life domains by removing barriers to services. The Council's focus will be education for children; supported employment for adults; and/or meaningful daily activities for older adults. Services shall be focused on Recovery and Resiliency**.**
5. Support education about mental illness and other mental disorders in an effort to reduce stigma.

As a result of Planning Council trainings and attendance to national conferences, the Planning Council has reorganized its structure to establish the following Standing Subcommittees to carry-out its mission and to meet its goals:

- Adult Consumer Subcommittee,
- Legislative/Administrative Subcommittee,
- Program/Planning Subcommittee,
- Children's Treatment and Services Subcommittee,
- Sexual Minority Treatment and Services Subcommittee,
- Older Adult Treatment and Services Subcommittee, and
- Ethnic/Cultural Minorities Treatment and Services Subcommittee.

For communication purposes, the Planning Council is at the apex of a triangle. The Legislative and Program/ Planning Subcommittees are the next step down. The five remaining Subcommittees form the base of the triangle.



Children's, Older Adults', Ethic Minorities', Adult Consumer & Sexual Minorities' Subcommittees

A representative of each Standing Subcommittee is designated in the Bylaws as a member of the Planning Council. Each Standing Subcommittee is charged by the Planning Council to focus their attention on the implementation of the Goals and Purpose of the Planning Council. Therefore, on the Planning Council Meeting Agenda, Subcommittee reports reflect the Planning Council Goal being discussed or implemented.

This increased expertise has been the MHPAC's focus on increasing consumer and family involvement at the onset of MHD policy, planning, and implementation endeavors. This supports the culture at the Division which supports the common goal of improving the quality of life for adults with severe mental illness and children with serious emotional disturbances.

MHPAC is interested in developing a subcommittee of youth over 2009. There will be details to work out such as time (after school hours), with schools for credit, travel arrangements and chaperones but the added benefit of youth voice should easily offset the work involved. MHPAC has just added a youth in transition to the Council. She will be impactful in combining the voice of the Council to the statewide Youth 'N Action group.

MHD supported five (5) MHPAC members in attending the Joint National Conference on Community Mental Health Block Grants and Mental Health Statistics held in Washington, DC May, 2008. In attendance was a representative from the Children, Older Adults, Adult Consumer subcommittee. This again was a valuable opportunity for the Council members, who not only gained resources and expertise, but who provided valuable input to the conference through their participation. MHD will send 4-5 MHPAC members to the 2009 conference.

We are pleased that the Chair of MHPAC is now representing Washington State on the Public Policy Committee.

Washington

Adult - Overview of State's Mental Health System

Adult - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.

As the public mental health authority for the 6,488,000 (OFM estimate of 2007) residents of Washington State, the Mental Health Division (MHD) operates an integrated system of care for people with mental illness who are enrolled in Medicaid as well as for those individuals who qualify as "low income" who also meet the statutory need requirements.

The public system operates the mental health crisis and involuntary treatment act for the citizens of the State. The Mental Health Division operates two adult State psychiatric Hospitals; one is in western Washington and one in Eastern Washington. Within the adult hospitals, there are two systems of care: civil and forensic.

Patients can enter the civil wards of the hospital through a voluntary admission (though this is rare as voluntary admissions are addressed through community hospitals) or through an involuntary civil commitment. There are processes whereby a patient may be civilly committed upon being discharged from the criminal justice system, or patients may be civilly committed without entering the criminal justice system.

Since the state hospitals are funded at a level tied to a legislatively defined "funded capacity" or census, the adult hospitals are at risk of over-expenditure if patients are admitted beyond the funded capacity, even though patients admitted under criminal statutes cannot be turned away. As state hospital civil capacity is an integral part of the community's resource for treating persons with mental illness, the RSNs are responsible for maintaining their use of state hospital capacity within contractual limits.

The current community mental health system operates under the following Statutory authority:

- Chapter 10.77 RCW - Provides for the commitment of persons found incompetent to stand trial or acquitted of a crime by reason of insanity, when found to be a substantial danger to other persons or that there is a likelihood of committing acts jeopardizing public safety or security unless under control by the courts, other persons, or institutions. Also provides an indigent person's right to be examined by court appointed experts.
- Chapter 71.05 RCW - Provides for persons suffering from mental disorders to be involuntarily committed for treatment and sets forth that procedures and services be integrated with Chapter 71.24 RCW.
- Chapter 71.24 RCW - Establishes community mental health programs through regional support networks that operate systems of care.
- Chapter 71.32 RCW – Authorizes mental health advance directives.
- Chapter 71.34 RCW - Establishes mental health services for minors, protects minors against needless hospitalization, enables treatment decisions to be made with sound professional judgment, and ensures minors' parents/guardians are given an opportunity to participate in treatment decisions.
- Chapter 72.23 RCW - Establishes Eastern and Western psychiatric state hospitals for the admission of voluntary patients.
- Chapter 74.09 RCW - Establishes medical services, including behavioral health care, for recipients of federal Medicaid as well as general assistance and alcohol and drug addiction services.

- Chapter 38.52 RCW - Ensures the administration of state and federal programs for emergency management and disaster relief, including coordinated efforts by state and federal agencies; and,
- a 1915b Medicaid waiver from the federal Centers for Medicare and Medicaid Services (CMS). The waiver allows the state to operate a managed care model.

Within the managed care framework, twelve (12) RSNs operate under two contracts to provide mental health services to persons across the lifespan with MHD. One contract is a Prepaid Inpatient Health Plan (PIHP) for Medicaid enrollees and the other is a State funded contract for non-Medicaid eligible persons or for non-Medicaid services to Medicaid enrollees called the State Mental Health Contract (SMHC). Under both contracts the RSNs are to ensure the provision of community inpatient and outpatient mental health services. While a few RSNs provide some direct crisis services to consumers, the majority of services are provided through contracts that the RSNs hold with Community Mental Health Agencies (CMHA) which then in turn deliver the services in their respective communities. Each RSN has a single separate Federal Block Grant contract.

Pierce County officials made a decision (effective January 2008) to not participate in the mental health managed care system therefore; the MHD quickly established a fee-for-service Medicaid system in this county. MHD contracted with all existing Community Mental Health Agencies in the County for the provision of the Medicaid services and the continuation of state funded service. For the federal block grant contracts for the first period of time, the MHD continued to fund what the former RSN funded to not disrupt service. However, for 2009, the Community Mental Health Agencies were treated as an RSN and had to plan accordingly. These agencies large and small, Tribal, corporate ran and consumer run, came together and develop individual plans that meet the needs of the consumers of the county, stayed within their budget and gained approval of the Pierce County citizen's Advisory Board.

MHD provides policy and collaboration with other Agencies and Departments providing mental health services. Included in that collaboration, but not limited to is:
- Division of Alcohol and Substance Abuse;
- Physical health;
- Department of Health;
- Division of Aging and Disability Services;
- Children's Administration,
- Office of the Superintendent of Public Instruction; and
- Department of Corrections.

Implementation of evidence-based, research-based and promising practices is occurring across the state for older adults, adults and children. The mental health system has been looking at the cultural barriers of implementation for certain populations.
A stronger relationship is developing with Washington's 29 federally recognized tribes and three non-federally recognized tribes as an important part of the mental health system for Tribal members. The DSHS Administrative Policy 7.01 ensures MHD operates in a

government-to-government relationship with the tribes. RSNs are also required to comply with the 7.01 Policy and must submit comprehensive plans to the MHD detailing tribal/RSN relations.

The Washington Medicaid Integration Project (WMIP) (operating in Snohomish County) contracts with Molina Health Care to make available a care coordination model, which is a team of care coordinators who will work with the clients to help identify health issues early, help coordinate services, and help the client follow-through with prescribed treatment. Coordination of these services is expected to accomplish the following:

- Prevent unnecessary hospitalizations;
- Postpone placement in nursing homes;
- Eliminate duplicate prescriptions; and
- Prevent the use of emergency rooms for treating conditions that are more appropriately addressed in physicians' offices.

The Chronic Care Management Program (CCMP) began January 1, 2007 is a program that provides care management and coordination activities for medical assistance clients determined to be at risk for high medical costs; 37% of those identified as appropriate for the program have been determined to have co-occurring mental health issues. The goals of the program are to improve access to appropriate services, outcomes and cost effectiveness of care for clients with chronic illness through care management interventions and to evaluate the program carefully to determine if CCMP interventions improve health outcomes and cost-effectiveness.

In addition to the work of the MHPAC, shifting the thinking of the RSNs for federal block grant to more transformative activities, the MHD called out priority focus areas for mental health 2009 federal block grant funds with the support of the Council. Those priorities are:

- homeless populations (with a focus on youth and families and where no PATH funding exists);
- older adults;
- consumer/family run programs,
- Local Tribal relationships, and added to this for MHD are:
- consumer, advocate, and family directed/driven promoted activities,
- vocational initiatives,
- residential support that promotes safe and affordable housing;

From the RSN plans we estimate that $433,973 will be spent on homeless related projects including some transitional housing, housing vouchers, utility assistance; $286, 944 will be spent on older adult projects including Gatekeeper project, outreach and screening, Alzheimer support groups, and older adult case management; $236,640 on Tribal projects which range from an elder outreach project, flex funds for youth and children, non-traditional services, outreach, education and training; and, $1,017,956 will be used for consumer and family activities such as Clubhouse, a Consumer Council, parent ran

organizations, consumer run organizations, WRAP training by certified WARP facilitators, supported education and NAMI training programs and support activities.

Washington

Adult - Summary of Areas Previously Identified by State as Needing Attention

Adult - A brief summary of areas identified by the State in the previous State plan as needing particular attention, including the significant achievements in its previous fiscal year.

The following points were previously identified in the 2008 plan as areas needing attention:

þÿ "Housing: Lack of safe and affordable housing

þÿ "Benefits: Too many individuals need mental heath treatment, yet are not eligible. State-only dollars cannot meet the call for services from this population.

þÿ "Inpatient Capacity: Secondary to the first two issues, rates of hospitalization are increasing.

þÿ "Vocational or Meaningful Activities: Too few employment related skills trainings are offered. þÿ T h e s a m e i s t r u e f o r o t h e r e life purpose and meaning.

þÿ "Understanding of Recovery and Resiliency: Need for more training and culture change in the mental health system to move toward Transformation.

All of the issues above are large system changing issues and have been identified through focus groups, the collection and interpretation of data derived from Consumer Satisfaction Surveys, the Prevalence of Serious Mental Illness in Washington State study, the URS and Developmental Tables, RSN reporting, hospital reports and jail reports, as well as, through the subjective input of MHD staff, the MHPAC, providers, multiple other community organizations, and consumer/ family voice.

Through the System Transformation Initiative (STI) that began in 2006 there were many planning processes to establish goals and develop improvements. These issues will continue to be the focus of the system throughout this biennium and the next. Through this work, many efforts have been undertaken and joint efforts have increased partnerships and collaboration.

The MHD has increased collaboration with the Division of Vocational Rehabilitation (DVR) and other employment service partners over the past year. This includes implementation of a statewide employment initiative and co-facilitation between DVR and MHD of a number of regional forums focused on increasing coordination between mental health programs and local DVR offices. MHD and DVR both participate on the Medicaid Infrastructure Grant (MIG) advisory committee. The MIG grant supports state-level efforts to enhance employment options for people with disabilities.

MHD has increased collaborative efforts with the Department of Community Trade and Economic Development (CTED) to promote the development of supported housing models. This includes co-sponsorship with the Washington Families Fund of eight local teams to participate in a Supported Housing Institute where each team will develop concrete proposals for the development of local permanent supported housing projects.

MHD continues to participate with the Economic Services Administration and Washington Association of Sheriffs and Police Chiefs in the statewide implementation of efforts to expedite the reinstatement of Medicaid eligibility for individuals with mental illnesses who are transitioning from jails and state hospitals.

The Inpatient Roundtable, a technical assistance group comprised of staff from MHD, the Health and Recovery Services Administration (HRSA), RSNs, and community hospitals, meets on a routine basis to consider community psychiatric hospital resource management.

MHD continues to be actively involved with the Department of Corrections in statewide efforts toward coordinating services for individuals with mental

illnesses being released from prisons. This includes coordination on the Community Integration Assistance Program for high risk individuals being released from prison.

Washington

Adult - New Developments and Issues

Adult - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

As described throughout this plan there continues to be ongoing focus on mental health and system transformation. New and ongoing issues that continue to impact service delivery are:

Ongoing

- System Transformation Initiative;
- implementation of Evidence Based Practices (EBP);
- development of the co-occurring disorders programs and the GAIN-SS screening and assessment;
- opportunity for a mental health treatment alternative to arrest for certain individuals; and,
- continued effort for cross system collaboration as the work within both the MHD and the Transformation Grant continues.

New

SHB 2654 ***Creating a process for certifying community-based mental health services***
The law requires DSHS/MHD must prepare a report on strategies for developing consumer- and family-run services. The plan must include amendment of the mental health waiver and state plan, and identification of funding and resources needed for implementation of services.

The report is being developed in cooperation with mental health consumers and family members, and will be provided to the Legislature by January 1, 2009.

SSB 6404 Modifying the process for designating regional support networks
This law established a process to replace a Regional Support Network that voluntarily terminates its contract or refuses to sign a contract with DSHS/MHD to act as an RSN.

A draft of the Request for Proposal (RFP) to secure a managed care entity for Pierce County was shared broadly with stakeholders in July 2008. The RFP allows for Governmental entities, not-for-profit and for-profit entities to bid on the contract, which is a change from the current RSN structure. The contract resulting from the RFP will begin in January 2009 with services being provided by July 2009.

ESSB 6665 Intensive Case Management and Integrated Crisis Response pilot program
These two pilot projects have had the expiration dates removed and the programs made contingent on funding provided in the biennial budget. The ICR pilot program is updated to allow for a 60-day less restrictive treatment order to be imposed following a patient's release from the secure detox center. Patients violating conditions of the less restrictive order may be returned to the secure detox center for up to 14 days. A definition of imminent" is added to Chapter 70.96B RCW, and rules for granting of continuances are provided.

SB 6739 ***Psychiatric Advanced Registered Nurse Practitioners***

This legislation authorizes psychiatric advanced registered nurse practitioners to perform several evaluative responsibilities (e.g. admissions, involuntary meds) related to people receiving inpatient mental health treatment.

Through the Integrated Mental Health managed care waiver, the state has authority for 1915 b (3) services. These Medicaid services are purchased through a process of identified savings and actuarial set rates. The b-3 services are clubhouse, respite and supported employment. CMS requested change in how the rates for these programs were set in our waiver. This has caused change in the way that some RSNs were planning to implement these services. Many RSNs will be using block grant funds for Clubhouse work for non-medicaid consumers and services.

Over the last several years the Washington State Legislature has provided state funding to lessen the impact of federal actions while enhancing funding for additional services, with increases specifically for mental health line staff wages/ cost of living. Additional people will be income eligible to receive Medicaid mental health services in 2009 because of Legislative action in 2008 (SSB 6583) to increase the income eligibility ceiling for Categorically Needy to 85% of the federal poverty level.

Between 2005 and 2009 $27.5 million was provided for community hospital in-patient rates for psychiatric services to reverse the trend of community hospitals eliminating psychiatric beds due to inadequate reimbursement rates. However, lack of inpatient capacity continues to be an issue for Washington State.

Additionally, the MHD has developed the WAC to certify clubhouses based on legislation in 2007. There was a 2-day conference in July 2008 with clubhouse staff to provide them an overview of expectations; a contract with WIMHRT for technical assistance is available to clubhouses to prepare. Clubhouses can begin to apply for certification in April.

Washington

Adult - Legislative Initiatives and Changes

Adult - Legislative initiatives and changes, if any.

þÿ W a s h i n g t o n S t a t e s l e g i s l a t i v e b o d y r e m a
improve our public mental health system. Through the creation of the Joint Legislative and Executive Task Force on Mental Health services and Financing (MHTF), the legislature has become more knowledgeable of the needs, concerns, and desires of those served by public mental health as well as more supportive of MHD and DSHS in efforts to facilitate change, growth and transformation.

The impacts of the legislative initiatives and changes listed below are fully described throughout the adult plan. Highlights include:
þÿ "Revised implementation date for Mental Health Insurance Parity
þÿ "Continued emphasis on STI
þÿ "Continued emphasis on system access and accountability
þÿ "Introduction of consumer and family ran business
þÿ "Continued opportunity for a mental health treatment alternative to arrest.
þÿ "Maintained emphasis on jail services
þÿ "Process for securing RSNs when a county can not or chooses not to participate in the public mental health system.

Washington

Adult - Description of Regional Resources

Adult - A brief description of regional/sub- State programs, community mental health centers, and resources of counties and cities, as applicable, to the provision of mental health services within the State.

Each RSN is a county or group of counties. Some counties within the RSNs have specific taxes dedicated to mental health. These are Spokane, King, Island, Kitsap, Snohomish, Clark, Okanogan, Clallam, Skagit and Jefferson. These tax dollars are outside of the scope of the public mental health system administered by the MHD. They do use these tax dollars for specific mental health projects. Several RSNs contribute local funds as part of their matching dollars for their capitation medicaid payment.
The community mental health providers also have available donation and other funds that they use for non-medicaid consumers.

The spreadsheet below are the funds distributed by the MHD.

RSN Estimated Revenues
Fiscal Year 2008 and 2009

	Fiscal Year 2008		**Fiscal Year 2009**		**2009 FBG**
RSN	Medicaid	Non Medicaid	Medicaid	Non Medicaid	
Chelan Douglas	5,652,572	2,364,353	5,812,871	2,749,824	97,688
Clark	18,173,581	8,058,246	20,035,660	9,450,360	372,564
Grays Harbor	5,182,551	1,703,086	5,339,593	1,539,738	65,003
Greater Columbia	36,697,142	12,174,757	39,184,714	14,228,328	602,658
King	80,140,396	37,394,218	83,385,917	43,892,832	1,694,590
North Central	14,431,594	3,450,439	15,164,408	4,154,168	193,715
North Sound	36,701,368	20,228,421	37,518,974	24,429,088	980,670
Peninsula	18,309,258	6,769,710	21,511,483	7,914,660	313,379
Pierce County	0	0	0	0	714,197
Southwest	6,434,105	1,778,644	6,520,980	2,092,356	89,378
Spokane	33,684,580	8,711,035	40,385,881	9,732,396	409,774
Thurston Mason	13,124,847	6,398,694	14,059,578	7,350,924	262,411
Timberlands	6,405,989	1,897,828	6,557,709	2,207,784	90,763
Total	274,937,983	110,929,432	295,477,769	129,742,458	5,886,792

Note: Non Medicaid revenue also includes funding related to Double Staff Bill (SHB 1456), Direct Care Wage Increase, Expanding Community Services (ECS), PALS, PACT and Jail Services

The table above provides estimates of the amount of funding available through the state of Washington to each Regional Support Network (RSN) for State Fiscal Years 2008 and 2009 based upon funding distribution formulas. This table does not include MHBG funding, the distribution table or which may be found in "Adult – Grant Expenditure Manner"

Many RSNs apply for grants, partnering with counties or other community agencies to increase their resource base. Additionally, the Community Mental Health Agencies with whom they contract may apply for grants, partner with

non-profit organizations or conduct other activities in support of enhancing their fiscal resources.

Funds can not be separated by age.

Washington

Adult - Description of State Agency's Leadership

Adult - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

As noted in the overview of the state's mental health system, the Mental Health Division (MHD) is the state authority for the administration of the public mental health services in Washington.

The Secretary of the Department of Social and Health Services DSHS is appointed by the Governor to this Cabinet-level position, overseeing several administrations within DSHS including; the Health and Recovery Services Administration (HRSA) which encompasses mental health, substance abuse and physical health, Aging and Disability Services Administration (ADSA), the Children's Administration (CA), the Economic Services Administration (ESA), and the Juvenile Rehabilitation Administration (JRA).

The MHD employed approximately 60 persons at headquarters and nearly 1,700 persons at the state hospitals. These numbers do not count the fiscal, IT and contract staff that are part of "shared-services" in HRSA.

Other division within HRSA include the:

- Division of Finance and Rate Development which provide fiscal and budget services for the administration;
- Division of Eligibility and Service Delivery which provide the Medicaid hotlines for clients and providers, including authorization lines, eligibility policy issues, CSO intake worker training and provider enrollment;
- Division of Healthcare Services which includes care management, quality oversight, family services, benefits management (FFS and managed care), and the coordinated care pilots: Medicaid Integration Partnership, GA-U managed care and the Chronic Care program;
- Division of Systems and Monitoring: the high tech services, audits and data sifting role and provides services and technical expertise to the entire administration. The division includes Claims Processing, the Veterans Project, Medicaid Eligibility Quality Control and consolidated IT services;
- Division of Alcohol and Substance Abuse;
- Division of Legal Services: comprised of rule writers, the Fair Hearings process, Human Resources, public disclosure, contracts and workforce advancement; and,
- Division of Disability Determination Services.

In the mid-1990s, Washington was granted a Medicaid 1915b waiver through the Federal Health Care Financing Administration (HCFA), now CMS. The waiver permits the State to purchase both outpatient and inpatient mental health services through PIHPs administered by RSNs. The amount of funding allocated to each RSN is determined by a capitated formula. The capitation rate is set by actuaries using Medicaid eligible, Medicaid services and trend factors. For our state only funds the MHD uses general population rather than Medicaid eligible.

MHD is currently responsible for the administration of a statewide integrated managed mental healthcare program. In FY07, this included community mental health services to 121,824 individuals, with 34,672 between 0-17 years of age.

Washington utilizes a 2-year budget, with the beginning of the biennium's first fiscal year starting on July 1 of odd-numbered years. In May 2007, of the Washington Legislature approved budget for FY07-09 biennium State budget over $19 billion (more than a third) allocated to DSHS. Of the DSHS budget, MHD's biennium budget was established at $1.3 billion (approximately $686 million per year), or about 7 percent of the DSHS budget. The 08 legislative budget supplemental was a total increase to the mental heatlh program of $13,951,000.

The Director, Richard Kellogg and the leadership in the MHD maintains a strong commitment to the need for input of consumers, parents and advocates and invites their participation in all stakeholder work. They recognize the need to educate the public on mental illness and to reduce the stigma associated with this disease. With the continued and growing involvement of the legislature, the many stakeholders involved in both the System Transformation Initiative and the Transformation Grant, awareness and understanding of this disease is increasing.

Another important area for the leadership of the mental health system is workforce development. Training is occurring throughout the system for workers from Mental Health Division staff through direct care and line staff as evidenced by the Behavioral Health Care conference, Case Management Training, Specialist training, Peer Counselor training, WRAP training, presentations and support at a variety of other agency conferences, the employment conference, the RSNs use of funds for training on EBPs and recovery and resiliency efforts, and other staff development activities.

MHD contracts with twelve (12) Regional Support Networks (RSNs). These RSNs serve as the managed care entity over the many Community Mental Health Agencies (CMHAs) with whom RSNs subcontract for the provision of direct care services. The MHD also directly contracts with Community Mental Health Agencies in Pierce County to provide Medicaid Services in a fee-for-service system and to operate the required state funded services.

MHD provides leadership to the RSN and Pierce County Providers via policy and standards, contract negotiation, development, execution, and monitoring. The Division also provides technical assistance upon request as well as offers support and training to RSNs in areas of identified need.

Although the Division holds its leadership role as extremely important in terms of conveying and overseeing the implementation the Governor's and State Legislature's intentions and initiatives, MHD holds strong beliefs in the need for collaboration with the Mental Health Planning and Advisory Council (MHPAC), allied systems, other state agencies, the Transformation Work Group (TWG), RSNs, the other formal providers of services to children and families, providers, and consumers/families/advocates at large.

In addition to oversight of the mental health system, MHD is responsible for resolution of consumer grievances and Fair Hearings that require State-level intervention as well as the

coordination of emergency preparedness and response to such incidents as natural disasters and acts of terrorism.

This year an example of the State's Leadership came about through its role as the coordinator of emergency preparedness through an incident of natural disaster. In December 2008, the western part of the state was faced with hurricane force winds and floods, a storm that was described by newscasters and weatherman as a "triple whammy". The first day of the three day storm brought to western Washington snow and ice when the jet stream from Alaska moved southward in Washington, the second brought in warmer temperatures and the beginning of heavy rains, the third day brought winds in excess of 85 miles per hour (official reports of 133+ at the coast, before the wind gauges toppled), high ocean surf and record-setting rain.

The flood created by the Chehalis River caused major damaged to three (3) counties in the state: Lewis, Thurston, and Grays Harbor. As many as 416 people in Lewis and Thurston Counties were rescued from their homes by the Coast Guard, the National Guard or by their neighbors with boats. Twenty miles of the major Interstate Highway (I-5) was closed for five-days due to the flooding of the Chehalis River. To reach Seattle from the Oregon boarder required motorist to take a 400 mile detour to central Washington and back across the Mountain pass into western Washington. This detour was necessary because many of the "back-roads" were covered by the same raising river or by mudslides. The estimated revenue loss to businesses in the Lewis County area due to the floods in $4,000,000 per day not including the damage to merchandise and buildings.

The winds in Grays Harbor were reported to be at Hurricane force on December 3. The winds toppled trees, blocked all roads into the county, and blew down the "power towers" leaving 33,000 residents without power in the County. The county was basically isolated.

In Grays Harbor, the effect of the flooding in Lewis and Thurston County by the Chehalis River did not occur for two days. As the flood water made its way to the Ocean it was met with high surf and high swell warning from a strong Pacific storm creating a tidal overflow. This flooding was met with the already flooded area of rivers and creeks from the storms on the previous week-end that it was in itself a second event.

Grays Harbor is also home to two Indian Nations, the Chehalis and the Quinault. The Quinault Nation had major damage including that of its substance abuse providers. The SA provider moved into Aberdeen in a building occupied also by the mental health center. The Nation had difficulty with power, water and basic needs.

In Pacific County, the winds again blew out power to the entire county the rains caused major flooding and mudslides and shut down roads and highways. The County remained without power and phone service for four days. Cellular phone service to Pacific County remained an issue due to the fact that the cell towers are located along the Oregon Coast and sustained damage. Small towns in Pacific County had houses where the roofs have been found blocks away, the school roof collapsed and the fair grounds, often the heart of

the rural community, was destroyed. The crabbers, which are a major industry in Pacific County, have reported in loss 75 % of their crab pots and for them, the season was destroyed which led to impact on the entire area.

In Mason County, the effects of the first part of the storm, where they received up to 18 inches of snow were barely over when the heavy rain and wind started. Mudslides closed many roads and destroyed many homes. The town of Tahuya which is located on a peninsula was completely shut off from the outside for two days and then the only access into the community was by boat. The National Guard was deployed to go house to house to check on the residents.

Both the community mental health system and the MHD stepped up to the plate to help the residents of these counties. The mental health system provided on the spot crisis counseling to the residents of the counties, the MHD staff responded by working with the Emergency Management Department and FEMA to implement a Crisis Counseling Program (Immediate Services Program (60-days)). The Immediate Services Program covered Thurston, Grays Harbor, Lewis, Pacific and Wahkiakum Counties as well as the Quinault Nation. Other affected areas of the state were covered under existing resources. Disaster Outreach Workers were trained to go door-to-door and to community events to provide the services under the Program. The MHD appreciates the support that it received from both FEMA and SAMHSA in this time.

MHD staff applied for and received an ongoing Regular Services Grant (9 months) from SMAHSA to continue the work of the Disaster Outreach workers in Lewis, Mason, Grays Harbor, Pacific and Wahkiakum Counties. The Quinault Nation and Thurston County will be covered under their existing services.

Washington

Child - Overview of State's Mental Health System

Child - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.

This is a largely joint response. Please also see Adult – Overview of State's Mental Health System.

The planning system and infrastructure for the delivery of children's mental health services is much the same as the adults. The RSNs and Pierce County Providers must provide a complete array of services to children and youth through sub-contracts with the local community mental health agencies for provision of direct care services to individuals in this vulnerable population who are found to have Serious Emotional Disturbances (SED) and for whom the medical necessity criteria are met.

Between nine percent and thirteen percent of children and youth (age 9-17) have serious emotional disturbances that affect their functioning in family, school or community activities. There are an additional number of children and youth identified by the school system as having a serious behavioral disability. These children and youth are served not only by the mental health and the school systems, but often times by the Children's Administration (child welfare system), Juvenile Rehabilitation Administration, physical medicine, Division of Alcohol and Substance Abuse, and/or the Department of Health.

Over the course of many biennia, training and technical assistance on the use of innovative methods of cross-system partnerships to deliver coordinated care have been provided. In addition, numerous local and national reports on coordinated care and best practices have been written. However, the funding and high level commitment in allied systems of care to support the growth and cohesion of children's services remains behind the coordination of care.

Youth may have multiple issues including: mental illness, substance abuse, repeated patterns of property destruction, assaultive behavior, sexually offending behavior, fire-setting behavior, and/or significant cognitive impairments. Children and adolescents with the most severe disorders usually have needs that require services from at least two child serving systems, along with medical care and other support. These children may have histories of being bounced from one service system to another including: child welfare, mental health, juvenile justice, substance abuse, developmental disability and special education.

All too often, children are not identified as having mental health problems and those who do not receive timely and effective services may end up in the juvenile justice system. At least three of the RSNs and one Pierce County provider fund through federal block grant dollars diversion programs from juvenile detention or co-fund with the facilities EBPs to help children and their families to stay in their homes.

It is important that care coordination exists for these children and their families. The family should not have the additional burden of coordinating with multiple systems that assist them. The systems should assume the responsibility to work together to serve the child/youth and their family. Additionally, it should not be necessary for parents to relinquish custody and care of their children to get services they need as has been the case in the past wherein a parent who could not meet the state eligibility criteria to obtain care

for their child made the difficult choice to relinquish custody, thereby making the child a ward of the state in order for the child to become eligible for services. MHD has a successful two-year pilot project using Multidimensional Treatment Foster Care (MTFC) in the Peninsula RSN. The pilot stays true to fidelity standards but parents are not required to place their youth in foster care to meet eligibility.

With the passage of HB 1088 last year, three pilot sites for fidelity WrapAround have began. These sites are in the North Sound RSN (Skagit County), Grays Harbor County and the Southwest RSN (Cowlitz County). The MHD has contracted with VroonVanDenBerg to provide readiness assessments and develop fidelity based programs. The first children and families were to be served beginning in July 2008.

Another interesting piece of HB 1088 is the review of the MHD's Access to Care Standards (ACS). These Standards were set as a Term and Condition of our 1915 b Medicaid waiver. The Centers for Medicare and Medicaid Services (CMS) required the MHD to establish statewide diagnosis and function into the public mental health system. This along with medical necessity is the entry point to the system. One of the allied systems outcries is that the ACS prevents children and youth from entering the system. While this is undocumented and MHD has asked repeatedly to be notified, if it occurred, a name has never been produced. However, this cry was heard by the legislature an three things occurred, 1) the number of mental health visits offered under the physical health care managed care system increased from 12-20; 2) the type of practioner that could provide the 20 visits expanded; and, 3) a review of the Access to Care Standards will occur with a report to the Legislature in January 2009. This review will also include an actuary analysis of the cost associated with the change. At the time of this writing, the change being considered is changing the CGAS score from 50 to 60. All of these benefit the mental health needs of children and their families.

The Mental Health Division operated one children's psychiatric hospital Child Study and Treatment Center and MHD also contracts with three Children's Long Term Residential Programs located in Seattle, Tacoma and Spokane. These facilities provide services to children in need of extended-stay treatment. The total bed capacity for the state is 91. This is currently causing some children to have long wait times for a bed. The MHD has identified in its Strategic Plan reducing the number of children waiting more than 30 days for admission from 17 to 14. Another issue identified is the lack of step down placement for children and youth leaving these facilities. The use of EBPs and the coordination with the Children's Administration could also create alternatives.

The Statewide Action for Family Empowerment of Washington (SAFE-WA) a parent organization supported by the Mental Health Division through MHBG funds and the Mental Health Transformation Grant, is in its fourth year with 501(c) 3 status. SAFE-WA is comprised of family-driven organizations and a youth organization from across the state. SAFE-WA meets every other month and develops monthly reports to bring a united voice to the Mental Health Division's management on prominent children's issues.

SAFE-WA is recognized by allied systems of the mental health structure resulting in an increasing number of conversations with other programs about the utilization of parents, neighbors and friends in the support of children with SED. The mental health system has received requests for technical assistance on the best way to incorporate family and friends into the planning process to help children with serious emotional or behavioral needs. Although this network of parents has become more accepted by providers as their community involvement expands, they are, unfortunately, not yet seen universally as a resource. This group, however, has a strong belief in their role as a system partner and plans to remain involved as coordination and recognition continue to grow.

Washington

Child - Summary of Areas Previously Identified by State as Needing Attention

Child - A brief summary of areas identified by the State in the previous State plan as needing particular attention, including the significant achievements in its previous fiscal year.

The following points were previously identified as areas needing attention in the 2008 MHBG Plan:

þÿ "Formal Systems Use: Continued utilization of inpatient care and involvement with the juvenile justice system is too high;
þÿ "Natural Supports: Too few families feel empowered or involved in the care of their loved one. More training and support are needed to enhance optimal use of this valuable natural resource. ;
þÿ "Understanding of Recovery and Resiliency: Increased community education on early intervention and preventions as well as Recovery and Resiliency are needed to infuse the system and child and youth consumers with hope;
þÿ "Educational/Vocational Activities: More support in education, jobs, and meaningful activities is needed to help children and youth become productive members of society. Too few programs exist for this age group; and
þÿ "Evidence Based Practice: Increased utilization of available evidence based
þÿ p r a c t i c e s i s c a l l e d f o r a c r o s s t h e e n t i r

þÿ T h e C h i l d r e n s M e n t a l H e a l t h A c t (S H B 1 0
þÿ a c t i v i t i e s r e l a t i n g t o c h i l d r e n s m e n t a l
next several years. By 2012, the Department is required to substantially
þÿ i m p r o v e t h e d e l i v e r y o f c h i l d r e n s m e n t a
will emphasize early identification, intervention and prevention. It will also
þÿ r e q u i r e c o o r d i n a t i o n a m o n g e x i s t i n g c a t e
programs and funding, and eliminate duplicative care plans and case management.
Among the systemic changes that are recommended are the greater use of evidence-based practices statewide, focus on resiliency and recovery, integration of educational support services and the achievement of specific performance based outcomes

Areas of attention also came from the System Transformation Initiative (STI), especially the needs of transitional youth for both housing and employment. STI continues to have a larger focus on children's mental health as a tie to the Children's Mental Health Act moves forward.

Washington

Child - New Developments and Issues

Child - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

As described throughout this plan there continues to be a growing focus on children's mental health and system transformation. New and ongoing issues that continue to affect service delivery are:

þÿ "The continued implementation of the Children's Mental Health Act. The selection of 3 pilot sites, North Sound RSN, Grays Harbor RSN and Southwest RSN. VaroonVanDenberg won the training RFP and has completed the readiness assessments in each area.
þÿ "The ongoing implementation of Evidence Based Practices and promising practices;
þÿ "The ongoing development of the co-occurring disorders programs and the GAIN-SS screening and assessment for youth;
þÿ "The ongoing work with STI regarding benefit redesign;
þÿ "A beginning discussion of transitional age youth and employment opportunities;
þÿ "The continued effort for cross system collaboration as the work within both the MHD and the Transformation Grant continues;
þÿ "The planned development of mental health specialist protocols with a conference scheduled in October 2008; and,
þÿ "The ongoing expansion of parent and youth involvement at policy level.

Washington

Child - Legislative Initiatives and Changes

Child - Legislative initiatives and changes, if any.

An opportunity for increased access to mental health services and requires several service package designs for Children, youth and their families is created through the Children's Mental Health Act. There are additional increased access points through the physical managed care plan Healthy Options for 20 mental health sessions (an increase of 8) and 20 fee-for-service visits for mental health with a psychiatrist, or other mental health professional. .

An emphasis on the values of WrapAround and through a RFP MHD awarded three pilot sites for fidelity WrapAround. The MHD contracted with VaroonVanDenBerg for readiness assessments which at the time of this writing are being completed. A few highlights of this legislation are:
þÿ "Treats each child in the context of his or her family,
þÿ "Provides services and supports needed to maintain a child with his or her family and community;
þÿ "Integrates families into treatment through choice of treatment,
þÿ "Integrates educational support services that address students' diverse learning styles;
þÿ "Recommends participation in treatment, and provision of peer support;
þÿ "Focuses on resiliency and recovery;

Through the contract and readiness assessment in two of the pilot sites, there is special emphasis on partnering with parents and the establishment of a parent network. the contractor has interviewed parents, interviewed staff, and will be conducting to parent/professional trainings in late September and early October.

Additionally, this legislation called for:
þÿ "A review of the Access to Care Standards of children's mental health both from a clinical and actuarial staff;
þÿ "An increase provider network; To date, there are seventy providers contracted with the Department to provide these 20 visits
þÿ "For schools and RSNs to collaborate in providing service through the RFP for the pilot sites; there were no joint RFPs submitted for this project.

Washington

Child - Description of Regional Resources

Child - A brief description of regional/sub- State programs, community mental health centers, and resources of counties and cities, as applicable, to the provision of mental health services within the State.

þÿ T h i s i s a j o i n t r e s p o n s e . P l e a s e s e e t h e Resources and note that we operate a capitated system and funds can not be broken out by age.

However, specific state funding has been dedicated specific to children's pilot projects.

The WrapAround pilot projects are funded at $1,059,000 state funding for state fiscal year 09. This funding is inclusive of the training provided by VaroonVanDenBerg and the EBP Institute at the UW.

The EBP pilot projects are funded with the following state funds.
þÿ "UW: $222,700 (for technical assistance and evaluation)
þÿ "Thurston Mason RSN: $435,350 including (MST, TFCBT with Skokomish Tribe, and a positive parenting program)
þÿ "UW MST: $37,950 (technical assistance and development)

Multidimensional Treatment Foster Care:
þÿ "Kitsap Mental Health: $662,110
þÿ "TFC Inc $36,740 (technical assistance and development)

If the RSNs fully implement their plans that $172,011 of their federal block grant will be spent EBPs on children and youth and $1,748,257 on children and youth related activities from parent support, psychiatric services, school support, outreach and engagement of non-medicaid children, to Tribal journeys.

Washington

Child - Description of State Agency's Leadership

Child - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

þÿ T h i s i s a j o i n t r e s p o n s e . P l e a s e s e e A d u
Leadership. However, these items are of most interest to children and youth.

MHD provides leadership to the RSN and Pierce County Providers via policy and standards, contract negotiation, development, execution, and monitoring. The Division also provides technical assistance upon request as well as offers support and trainings in areas of identified need.

Through the statewide integrated managed mental healthcare program, 34,672 children under the age of 18 received services in FY07.

With the additional focus on children's mental health issues, the MHD is working in a collaborative fashion with the Children's Administration, Juvenile Rehabilitation Administration and the Office of Superintendent of Public Instruction. Additionally, MHD is working closely with physical health care to examine the types and amounts of psychotropic drugs prescribed to children. Over this past year and continuing into 2009 there has been a workgroup of pediatricians, psychiatrists, psychologists and nurses hosted by the MHD Director, Richard Kellogg and the Health and Recovery Services Administration, Medical Director, Dr. Jeffery Thompson to review the use of psychotropic medication for children.

Parents are also participating with the MHD on the consumer and family operated services report due to the legislature in January 2009.

Washington

Adult - Service System's Strengths and Weaknesses

Adult - A discussion of the strengths and weaknesses of the service system.

þÿ W a s h i n g t o n s s t r e n g t h s i n c l u d e :
þÿ "A diverse and inclusive community support system;
þÿ "A cross-system, legislatively driven, resource for co-occurring disorders including crisis intervention and treatment through the Omnibus Bill;
þÿ "Legislation requiring more rapid implementation of mental health parity;
þÿ "A steady increase in consumers becoming Peer Counselors.
þÿ "A commitment to provide increased support and training for use of evidence based practices across all populations including children, older adults, other vulnerable populations with severe mental illness and serious emotional disturbances;
þÿ "MHD, in partnership with Indian Policy Service and Supports (IPSS) has reinstituted the Monthly Tribal Mental Health Workgroup. The purpose of this workgroup is to improve collaboration between the MHD and the Tribes, address policy issues and concerns and to improve tribal mental health services. This year MHD and IPSS have convened a Roundtable discussion for the purpose of the development of the 2010-2012 waiver renewal. Beginning this discussion this early will assure that the Tribes are involved in the decisions and that formal Consultation occurs in a timely manner.
þÿ "The ongoing implementation of ten PACT teams statewide;
þÿ "Training for workforce development trough conferences both state and Nationally;
þÿ "The ongoing implementation of a cross-system co-occurring disorders screening;
þÿ "A ongoing intensive chemical dependency case management pilot in two RSNs;
þÿ "þÿ A c o m m i t m e n t t o t h e t r a n s f o r m a t i o n o f Strategic Plan as well as this document.

Because the community mental health system is funded under a capitation arrangement with county-based RSNs receiving monthly payments intended to cover the cost of providing mental health services in their catchment areas, funding is not identified to specific clients, nor is it targeted for certain services or programs. Rather, RSNs are directed to accomplish all of the requirements in the contract with the overall funding they receive. Increased funding and greater consistency between RSNs is a constant goal.

The legislature funded in 2007 the implementation of innovative services through pilot projects. Through a RFP process, there was funding awarded to the expansion of five clubhouses, two programs of coordinated care between physical and mental health for low income persons and a final project to create a specific clubhouse and peer support project for the Asian Pacific Islander population. These projects were funded again in 2008 year with the exception of one clubhouse that is no longer in business. For 2009, the innovative services money will support seven of the projects at a 90% funding level.

While the community mental health system in Washington holds a strong and positive foundation, there are always opportunities for improvement.

Services need to be consumer driven and based, accessible to all who need them, and stakeholders (including legislators, law enforcement, administrators, providers, consumers, family members, advocates, children, youths, and the community at large) must understand that every consumer holds the ability to attain recovery and that children and youth can improve their resiliency.

While not Washington's challenge alone, the reduction of stigma must continue so that every individual possesses the right to have a meaningful life in their own community

Washington

Adult - Unmet Service Needs

Adult - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

All of the issues below have been identified in the past as unmet needs. However, these are large undertakings and can not be completed in a year or even two. These have all been identified through focus groups, the collection and interpretation of data derived from Consumer Satisfaction Surveys, the Prevalence of Serious Mental Illness in Washington State study, the URS and Developmental Tables, RSN reporting, hospital reports and jail reports, as well as through the subjective input of MHD staff, the MHPAC, providers, multiple other community organizations, and consumer/ family voice.

þÿ "Housing: Lack of safe and affordable housing

þÿ "Benefits: Too many individuals need mental heath treatment, yet are not eligible. State-only dollars cannot meet the call for services from this population.

þÿ "Inpatient Capacity: Secondary to the first two issues, rates of hospitalization are increasing.

þÿ "Vocational or Meaningful Activities: Too few employment related skills trainings are offered. þÿ T h e s a m e i s t r u e f o r o t h e r e life purpose and meaning.

þÿ "Understanding of Recovery and Resiliency: Need for more training and culture change in the mental health system to move toward Transformation.

Washington

Adult - Plans to Address Unmet Needs

Adult - A statement of the State's priorities and plans to address unmet needs.

Washington is continuing to experience an unprecedented focus on the mental health system. With everyone involved from consumers and family members, to the Governor's Office, MHD has a grasp on where, in our continuum of care, needs exist.

As with most public mental health systems, Washington State struggles with limited resources to meet the basic needs of its consumers. As we move forward to implement the changes intended to promote consistency and more equitable access to high quality services, we remain aware of potential shortcomings within the system that must be a priority as well.

The MHD continues implementing a comprehensive package of budget and legislative initiatives in the delivery of Washington State's public mental health services for adults with severe and persistent mental illness and children with serious emotional disorders based on unmet service needs. Strategies include:

1. Statewide implementation of Program of Assertive Community Treatment (PACT) teams.
2. A study of the Medicaid benefits package and Medicaid managed care rates.
3. Preparation of a plan for expanding housing options for individuals with mental illness.
4. A review of Washington State's involuntary commitment statute and system.
5. Development of a utilization review system to assure people receive appropriate levels and durations of state hospital and community psychiatric inpatient care.

***Housing*:** The MHD continues its contract with Common Ground, a non-profit consulting firm focused on creating and preserving housing for people with low incomes and special needs, to develop the statewide mental health housing plan. The Housing Action Plan promotes recovery and addresses the increasing demand for beds at Eastern and Western State Hospitals with the goals to:

• Assess the availability of housing for people with severe and persistent mental illnesses and identify key barriers to securing community-based housing;
• Describe evidence-based practices and models for community-based housing;
• Propose models, partnerships, contracting approaches, and financing options for community-based housing that can meet the needs of the diverse populations served by the public mental health system;
• Provide a specific action plan for creating/securing an additional 500 housing units; and
• Provide technical assistance to RSN's, providers, and consumers to build the capacity at the local level to develop housing, design and implement housing programs, and/or partner with landlords to secure housing.

The Housing Action Plan focus is on community-based housing models that have demonstrated success in increasing stability, reducing episodes and length of stays in hospitals and jails, and promoting recovery

The Housing Action Plan includes a description of necessary supports, barriers, and outcomes. Examples of necessary supports include landlord education and incentives or

coordination of state housing and service dollars. Examples of barriers to appropriate housing include high rental costs, felony convictions, or cultural and language differences. Examples of appropriate outcomes are:

1) Increase in the number of consumers who secure stable permanent housing;
2) Increase in the average length of tenancy for consumers in permanent housing; and
3) Reduction in the frequency and duration of hospital or jail stays

Benefits: The MHD continues to contract with TriWest Group to make recommendations for re-designing its benefit package for publicly-funded managed behavioral health care and to assist with the consumer and family ran business report. The first phase included compiling a detailed overview comparing Washington's current benefit design with national best practices and benefit designs from comparison states. This included:

- A review of Washington's Medicaid State Plan and broader mental health benefit design;
- A literature review of national best practices including evidence-based and other culturally relevant and promising practices;
- An analysis of comparison states Medicaid benefit plans; and
- Input and guidance from Washington stakeholders.

The second phase of the project focused on refining the preliminary recommendations and developing a transition plan that takes into account the statewide system transformation initiative that is taking place. The transition plan will address both the recommended benefits and the financial implications and will include:

- Additional focus groups with a full range of stakeholders, including consumers of the mental health system and their parents, family members, providers, RSNs, Tribal representatives, and allied systems; and
- Working closely with MHD staff and targeted stakeholders to make sure the emerging plan is both administratively and financially feasible and that it reflects the priorities of the department.

All project work culminated in a final report that will include the final recommended benefits and financial implications along with cost projections.

Utilization Review: The Utilization Review (UR) Project will produce recommendations for statewide criteria and processes for external utilization review of State and community hospitalizations for the State of Washington. The goal of an external utilization review criteria and processes will be to ensure appropriate levels of state and community psychiatric inpatient and community-based services which support the recovery of individuals with severe and persistent mental illness.

As part of the process of developing criteria, the UR Project will accomplish the following:

- Establish acuity levels and criteria for individuals to be supported in community and psychiatric inpatient settings as well as for individuals to be supported in community outpatient programs based on current access to care standards, involuntary treatment statutes, and other state and industry standards;
- Develop standards for review of short-term hospitalizations; and
- Develop sampling methodologies and processes for independent review of 90 and 180 day commitments in community and state hospitals and freestanding Evaluation and Treatment Centers.

Vocational or Meaningful Activities: Enhanced supports to help those consumers who want to work or go to school do so, as evidence shows that feeling productive and having purpose in one's life is critical to not only decreasing one's symptoms, but to making meaningful recovery a reality. Particular focus will be given the expansion of Peer Counselor certification program and to the development of Clubhouses.
MHD anticipates expansion of peer support by increasing the number of trainings in the upcoming year and by an internet site devoted to this model of care focused on Recovery and Resiliency. The Peer Counselor training manual will also be updated and plans are to translate to Spanish and target special training efforts for the Spanish speaking population.

Wellness Recovery Action Plan (WRAP) is provided to all certified Peer Counselors as well as others interested in this dynamic, evidence-based program.

Pierce Community College in Tacoma continues to have a strong supported education program for consumers with mental illness wanting to return to school. Currently they serve about 40 consumers

The SEER program at Spokane Falls Community College in Spokane continues to be active. Currently they serve approximately 228 consumers.

Understanding of Recovery and* Resiliency*: Increased training is expected in early intervention and prevention, cultural competency, and community education, thereby decreasing discrimination and stigmatization. MHD will continue to encourage and solicit expansive involvement of consumers in directing the mental health service delivery system in Washington, ultimately empowering them to take responsibility for themselves and realize their right to the pursuit of happiness.

Legislation was passed in 2007 for the MHD to certify Clubhouses. This process is beginning with stakeholder input. Additionally, Washington's Medicaid waiver has required mental health clubhouses as a Medicaid service which has increased the number of clubhouses across the state. In 2008, as a result of the legislation, Washington Administrative Code (WAC) was written and approved to certify the Clubhouses. This certification process will begin in September 2008.
MHD anticipates expansion of peer support by increasing the number of trainings in the upcoming year and by an internet site devoted to this model of care focused on Recovery and Resiliency. The Peer Counselor training manual will also be updated and plans are to

translate to Spanish and target special training efforts for the Spanish speaking population.

In addition, the MHD provides scholarships for consumers and staff to attend workshops and conferences, it is anticipated that 153 scholarships will be offered again this year to the Behavioral Health Care Conference, 10 scholarships to the co-occurring conference, and additional scholarships to the Alternatives Conference.

The RSNs each provide training and education opportunities to their consumers though a variety of activities such as:

- NAMI trainings (In our own Voice, Peer to Peer, Family to Family)
- Pebbles in the Pond
- Recovery training
- Training on Evidence Based Practice
- Medication management and the possible side effects
- developing budgets and financial skills
- Board training
- Cultural trainings such as a Canoe Journey and cultural nights
- general wellness education

An activity of interest is a prevention policy effort of the Transformation Project. Prevention teams from multiple disciplines are working towards recommendation for the 2009 legislature.

Washington

Adult - Recent Significant Achievements

Adult - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

- **Substitute Senate Bill 5533**: **Chapter 375, Laws of 2007**. This legislation is intended to provide an opportunity for a mental health treatment alternative to arrest for certain individuals. Provisions include:
  - Authorization for police officers to divert individuals with mental illness who have been alleged to have committed misdemeanor crimes, which are not serious crimes, to mental health treatment;
  - Police officers diverting such individuals are provide liability protection;
  - Authorizes the licensing and certification of a new type of mental health residential facility, "crisis stabilization unit" to provide an additional mental health treatment resource for these individuals; and
  - Authorizes the crisis stabilization units to detain the individual up to 12 hours and requires provision of additional voluntary mental health services.

- **Substitute House Bill 1456**: **Chapter 360, Laws of 2007**. Known as the "Marty Smith Bill" in honor of a mental health professional killed on the job, this legislation is intended to provide greater personal safety to mental health professionals. Provisions include:
  - Annual training on safety and violence prevention for all community mental health workers who work directly with clients;
  - Policies to ensure that no mental health crisis outreach worker will be required to conduct home visits alone;
  - Employers will equip mental health workers who engage in home visits with a cell phone or other communication device; and
  - Mental health workers dispatched on crisis outreach visits will have prompt access to any history of dangerousness or potential dangerousness on the client they are visiting, if available.

- **Enhanced opportunity for system and community collaboration**: The Mental Health Division (MHD) continues to actively work to strengthen relationships with all stakeholders in the mental health system. Major partners include the Regional Support Networks (RSNs), consumers, families, MHPAC, Transformation Work Group, community mental health providers, state hospital patients, labor unions and allied systems. Some of these allied systems include formal systems such as the Children's Administration, the Aging and Disability Services Administration, the Division of Alcohol and Substance Abuse, the Division of Developmental Disabilities, the Office of Superintendent of Public Instruction, the Department of Corrections, and the Division of Vocational Rehabilitation, to name a few.

  MHD leadership and staff members meet regularly with RSN administrators and assure that there is representation from the RSNs on any committee created to develop or establish policy. These committees may also include providers, consumers, parents and family advocates and, at times, allied system partners. Topics for discussion range from the call for evidenced based practices to the need for Washington Administrative Code changes.

- **Increased efforts to coordinate physical and mental health:** Washington's Medicaid Integration Project (WMIP) continues today, through the collaboration of DSHS with Molina Healthcare of Washington, Inc (Molina). The goal is to manage and provide medical, mental health and chemical dependency services through Molina's provider network, with an initial requisite enrollment of 6,000 individuals (with option to disenroll) for the residents of Snohomish County. The focus of this project is to make available a care coordination model through a team approach to work with the clients to help identify health issues early, help coordinate services, and help the client follow-through with prescribed treatment. Coordination of these services is expected to accomplish the following:
    - Prevent unnecessary hospitalizations;
    - Postpone placement in nursing homes;
    - Eliminate duplicate prescriptions; and
    - Prevent the use of emergency rooms for treating conditions that are more appropriately addressed in physicians' offices.

- **Increased avenues for consumer participation and representation**: A State-wide Consumer, Family and Youth Network is being developed under the leadership of consumer staff involved in the Transformation Grant. The intention is to help build an independent and sustainable coalition that will eventually attain 501(c) 3 status. The Network will facilitate a more unified consumer voice regarding the direction of the mental health system.

- **Expansion of Peer Counselor and Recovery training:** Consumer training and employment continue through comprehensive training and certification programs for Peer Counselors. There are now 482 trained Peer Counselors of which, 208 are certified. Another 114 have passed the exams and are awaiting license from the Department of Health. 119 have been trained of which 97 are currently invited to testing. There are 132 people on waiting lists at the time of this writing. There are two more trainings scheduled before November of 2008 which will serve 50 individuals from this list. However, new applications arrive daily. In 2009, training will be continuing both sponsored by the MHD and by the RSN.

  The term, ***"consumer"*** *is defined in the Washington Administrative Code (WAC) and includes the parents or legal guardians of children under the age of 13 and when they are involved actively in the treatment of the child over age 13.* Individuals applying for certification must be Registered Counselors with the Department of Health, must successfully complete forty hours of in-class training that is experiential and informational in format and the individual must pass both oral and written exams. Accommodations are provided for individuals with special needs and every opportunity is provided to enhance the success of the participants.

  Upon completion of the requirements for peer counselor based on the Medicaid State Plan, a letter of completion is issued by the MHD verifying that the minimum qualifications have been met. Licensed community mental health

agencies are beginning to hire and employ peer counselors to meet the requirement that all state plan services be available in each RSN. MHD anticipates expansion of peer support by continuing the trainings in the upcoming year and by enhancing an internet site devoted to this model of care focused on Recovery and Resiliency.

Wellness Recovery Action Plan (WRAP) is provided to all certified Peer Counselors as well as others interested in this dynamic, evidence-based program.

In an effort to increase collaboration between MHD and Transformation Grant initiatives, staff members from both entities have been meeting regularly to develop and implement Recover***y*** and Resiliency trainings across life-span, socio-economic, and cultural/ethnic boundaries.

- **Increase resources for persons with co-occurring disorders**: MHD and the Division of Alcohol and Substance Abuse staff the Co-Occurring Disorders Interagency Committee made up of providers from mental health, chemical dependency, other cross-systems and consumers. This group, having been in existence for approximately thirteen years, continually seeks to address the co-morbidity issues of mental illness and substance related disorders. The two divisions often engage in joint studies including developing a joint demonstration project serving persons with co-occurring disorders in Yakima.

- **Mental Health Insurance Parity:** With the passage of House Bill 1460, comes another significant transformation activity. This legislation holds the requirement that insurance carriers in Washington State provide parity between mental health services and medical /surgical services. Specifically, co-payments, prescription drug benefits, out-of-pocket expenses, deductibles, and treatment limitations for mental health conditions must be the same as those for traditional physical health conditions and moves the original implementation date forward. This is a significant step forward in strengthening the continuum of care, increasing access to mental health services, and for thousands of Washington's residents who struggle with mental health issues.

- **DD/MHD Collaborative Work Plan:** Through this innovative working agreement, MHD and the Division of Developmental Disabilities have worked to improve access to services, appropriateness of treatment, and accountability for services. Its keys to success have been that fact that it is formalized in writing, funded through the legislature, and facilitated by the DD/MHD Cross-System Committee, with the support of state-wide regional coordinators and the written reports from monitors with national expertise. The results of this program have been profound. Over 173 residential slots have been created in the community for this population; more people are leaving the hospital than entering, fewer are being admitted, of those admitted, fewer are entering the hospital for the first time, fewer are being re-admitted once discharged, and the length of time between hospitalizations has increased dramatically:

- **Support of Evidence Based Practices:** In addition to the development of PACT teams, MHBG funds are being used to support development of EBPs specific to Older Adults included training on the implementation and use of the evidence based practices of PEARLS (Program to Encourage Active Rewarding Lives for Seniors) and IMPACT (Improving Mood and Promoting Access to Collaborative Treatment) for late life depression. MHD will continue to actively enhance the outreach capacity and specialized services needed by this traditionally underserved population.

- **Improved Tribal Relations and Supports:** The Tribal Liaison position at MHD provides coordination with Washington's 29 federally recognized tribes in addition to three non-federally recognized tribes as an important part of the mental health and tribal coordination. The DSHS Administrative Policy 7.01 ensures MHD operates in a government-to-government relationship with the tribes. RSNs are also required to comply with the 7.01 Policy and must submit comprehensive plans to the MHD detailing tribal/RSN relations.

  In 2009, MHD will increase the MHBG funds that are available for the Tribes from the 20% maintained and the RSNs are required to consider the Tribes and Tribal members living in their service area when they submit their spending and service plans.

- **Increased focus on MHBG funds:** MHD has continued conducting on-site program and fiscal reviews of each RSN related to the use of MHBG funds. These reviews, which are resulting in improvements in accountability and consistency, are followed up with technical assistance from MHD for those RSNs needing help in the development or enhancement of their tracking and monitoring policies, procedures, and accounting practices. Additionally, the review process of RSN MHBG plans which began in 2007continues.

  RSN MHBG plans are reviewed by the Council, they are also reviewed by a cross-section team of MHD staff, then the team and members of MHPAC compare their reviews and the state planner sends joint comments back to the RSN.

  The review uses the following process:

  The review teams first apply the identified *guiding principles* and *spending categories*. The team then reviews two required pieces of the proposal approval process. First, the RSN must provide a narrative description of how the services it is planning on supporting will promote Transformation, Recovery or Resiliency. The second requirement is that the RSN demonstrate that its' Advisory Board (which is required through WAC to have >51% Consumer membership) has had involvement in development or review of the RSN's plan as evidenced by either meeting minutes or a letter of opinion on the proposed plan. Each group

separately makes comments on the plan and then they share their comments. All comments and questions are fed back to the RSN for answers and/or change. Contract negotiations always take into consideration the comments and question/answers.

For 20% of the funds that stay at the MHD, the cross-system team reviews the proposals in the same manner as above. They send both program and fiscal recommendations to the MHD Director for approval or denial of the proposal. The beginning of each fiscal year, the plan for the 20% expenditure is shared with the MHPAC. However, most funds are used to support the areas identified as needing attention or transformational activities.

Washington

Adult - State's Vision for the Future

Adult - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

MHD vision for the future is provide our citizens with the highest quality of mental health services available; services that are consumer driven, evidence based, outcome directed and supportive of individual recovery and/or resiliency.

For the Division:

þÿ "Continued efforts to address the legislative questions and maintain accountability for the public stewardship we are given through a highly skilled workforce within MHD;
þÿ "Staffing at adequate levels to accomplish the exceptionally challenging and powerfully important work that lies before the Division.
þÿ "Expansion and inclusion of consumer and family voice to guide the mental health system toward greater alignment with the over-arching goals of the
þÿ P r e s i d e n t s N e w F r e e d o m C o m m i s s i o n r e c o m

For the State Mental Health System:

þÿ "Both outpatient and inpatient care that is based in Recovery and Resiliency;
þÿ "Staffing at adequate levels to meet the needs of persons living with mental illness in the community;
þÿ "Housing that is safe and affordable for those we serve;
þÿ "Vocational opportunities for adults and youth with mental illness that are meaningful and feasible;
þÿ "Services that are culturally competent and accessible to all who are eligible;
þÿ "Services that are person-centered and self-directed;
þÿ "Access to services that are cohesive and well coordinated, demonstrating
þÿ e n h a n c e d r e l a t i o n s h i p s b e t w e e n s t a t e a g e
consumers, families, and communities, facilitating a seamless continuum of care.

To achieve these goals, MHD will continue to focus on transformation. Accordingly, in determining how MHBG funds are utilized, the Division uses the six guiding principles below. Proposed uses of MHBG funds must:

1. Be in concert with the National Outcome Measures and fall within the parameters of the MHBG assurances and requirements;
2. þÿ W o r k i n t a n d e m w i t h t h e D i v i s i o n s S t
þÿ u p d a t e d i n c o l l a b o r a t i o n w i t h t h e M H P A C
the Promise: þÿ T r a n s f o r m i n g M e n t a l H e a l t h C a r e i n
3. Hold meaningful and measurable outcomes that are in line with articulated consumer/family voice;
4. Link well to other resources and transformation activities;
5. Meet needs in our system that are not fulfilled elsewhere, allowing for minimal negative impact on other service agencies if funding is not approved; and
6. Align well with other Division initiatives or legislatively mandated expectations

Washington

Child - Service System's Strengths and Weaknesses

Child - A discussion of the strengths and weaknesses of the service system.

In Washington State we have the following strengths in our child/youth system:

- A diverse and inclusive community support system;
- A cross-system, legislatively driven, resource for implementing Wraparound pilot sites;
- Legislation requiring more rapid implementation of mental health parity;
- Legislators with a strong tie to children's mental health;
- A steady increase in Peer Counselors (including parents).
- A commitment to provide increased support and training for use of evidence based practices.
- MHD, in partnership with Indian Policy Service and Supports (IPSS) has reinstituted the Monthly Tribal Mental Health Workgroup. The purpose of this workgroup is to improve collaboration between the MHD and the Tribes, address policy issues and concerns and to improve tribal mental health services including children and youth issues.
- Training for workforce development trough conferences both state and Nationally;
- The ongoing implementation of a cross-system co-occurring disorders screening;
- A Family organization of parents willing to assist us when needed.
- An exceptional and growing network of dad's (WA Dad's) that have brought new light to the need for support for dad raising children with serious emotional disturbance.
- A growing Youth movement across the state.
- A joint meeting held semi-annually with the RSN children's care coordinators, the Children's Administrations Regional Representatives and the RSN Parent Advocates to share strengths and challenges.

The following Evidence Based Practices are being used in the state

- Multi-dimensional Treatment Foster Care (MTFC);
- Functional Family Therapy (FFT);
- Trauma Focused Cognitive Behavioral Therapy (TF-CBT);
- Family Integrated Therapy (FIT); and
- Multi-systemic Therapy (MST).

Implementation and delivery of services based on these EBPs are described throughout the plan. Treatment outcomes for children, youth and their families should result in placement stability, improved educational achievements, reduced out of home placements, reduced use of restrictive treatment options and overall improved quality of life and enhanced resiliency.

Youth 'N Action's eastern Washington youth group received the following honor: "Youth 'N Action was awarded the Chase Youth Commission's "Courage" award last night (3/27/08) at a ceremony attended by over a thousand at Whitworth's Cowles Auditorium. Spokane's Mayor Mary Verner, Congresswoman Cathy McMorris Rodgers, and County Commissioner Bonnie Mager were among many other public officials, area business owners, and city leaders in attendance at the evening's formal event.

Youth 'N Action was honored for the courage of its members in overcoming great odds (homelessness, violence, mental illness, etc.) to be able to successfully make a difference in their communities through their service projects, the planning of a ground-breaking youth collaboration summit, their Art For Understanding project, and for improving youth relations with law enforcement. Youth 'N Action was chosen over 30 other nominees. Over a dozen Youth 'N Action members and their parents and friends were present to receive the award.

With the award came personal letters to Spokane Youth 'N Action members and staff from Governor Christine Gregoire, Senator Maria Cantwell, Congresswoman Cathy McMorris Rodgers, and others.

Governor Gregoire wrote, "I was delighted to learn that Youth 'N Action was being recognized for Courage... ...you are among the finest young people in Spokane County, and I applaud your hard work and dedication."

Youth 'N Action members each received a certificate of recognition, a gift certificate, and a large plaque was awarded to the organization. After the ceremony, Mayor Mary Vernor told Youth 'N Action's Director, Ryan Oelrich, that she had heard about the great work YNA was doing in improving communication with law enforcement and invited further dialogue".

While the community mental health system in Washington holds a strong and positive foundation, there are always opportunities for improvement.

Because the community mental health system is funded under a capitation arrangement with county-based RSNs receiving monthly payments intended to cover the cost of providing mental health services in their catchment area, funding is not identified to specific clients, nor is it targeted for certain services or programs, this at times “pits” one population against the other for funding. Rather, RSNs are directed to accomplish all of the requirements in the contract with the overall funding they receive. Increased funding and greater consistency between RSNs is a constant goal.

Parent Peer Counselors are not in every area of the state. While some agencies employ parent partners to do similar work as a Peer Counselor, the system has not as a whole recognized the importance of parents as peers in the system.

SAFE-WA, Youth ‘N Action, and WADAD’s do not yet have membership that is statewide, nor is organizations recognized as a support to the system uniformly.

Washington

Child - Unmet Service Needs

Child - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

While considerable progress continues to be made in many parts of our system, the following are large areas require more work to be done in facilitation and þÿ c o o r d i n a t i o n o f c a r e a c r o s s W a s h i n g t o n s children and will take more than one year to accomplish, therefore, the items below continue as unmet needs.

þÿ "Formal Systems Use: Continued utilization of inpatient care and involvement with the juvenile justice system;
þÿ "Natural Supports: Too few families feel empowered or involved in the care of their loved one. More training and support are needed to enhance optimal use of this valuable natural resource. ;
þÿ "Understanding of Recovery and Resiliency: Education for children, youth and their families on Recovery and Resiliency is needed as well as for the system to hear from youth and families to ensure the meaning of the language the same.

þÿ "Early Intervention and Prevention: Increased community education on early intervention and preventions.
þÿ "Educational/Vocational Activities: More support in education, jobs, and meaningful activities is needed to help children and youth become productive members of society. Too few programs exist for this age group; and
þÿ "Evidence Based Practice: Increased utilization of available evidence based þÿ p r a c t i c e s i s c a l l e d f o r a c r o s s t h e e n t i r

Washington

Child - Plans to Address Unmet Needs

Child - A statement of the State's priorities and plans to address unmet needs.

Through the efforts below, the goal of MHD is to ensure that children with SED are treated and strengthened by the services provided to them so that they do well at home and school, enjoy better health and ultimately come to realize their dreams, and those of their family.

þÿ "Formal Systems Use: As a follow-up to last year's workgroups regarding to þÿ a s s e s s t h e C h i l d r e n s L o n g - t e r m I n p a t i e n acute care resources available to children and youth there are four separate groups working to improve parent partnerships, access, standard terms and definitions and other related activities. Greater collaboration is occurring with JRA and there is a requirement in SSHB1088 to explore Medicaid eligibility for youth when they are in detention to ensure coordinated after care. Collaboration with Children's Administration, DASA and physical health are active at the state and RSN level.
þÿ "Natural Supports: MHD will continue to support activities and trainings which are geared toward enhancing familial empowerment and participation in the care and treatment of children and SED including contracts with SAFE-WA, þÿ c o n t i n u i n g t o s u p p o r t t h e g r o w i n g D a d s training and Conferences, and the Parent Community Connectors.
þÿ "Parents who have children in the Long Term Residential Programs often feel isolated and alone. MHD has provided two training specific to their needs and will continue to support these parents while their children are in residence. MHD anticipates this training will continue in 2009.
þÿ "Understanding of Recovery and Resiliency: The need for a comprehensive Recovery and Resiliency training and the relationship to children and youth is well understood. MHD has formed a collaborative workgroup with members of the Transformation Work Group to address the need for such a state-wide initiative. The vision of educating consumers, families, providers, administrators, as well as the general public is held in hopes of realizing meaningful outcomes and reducing stigma. MHD will continue to work to ensure that language is consistently used. Though our MHBG funds MHD will provide funding to assist parents in visiting their child both to participate in treatment activities but, to also allow them some time as a family unit.
þÿ "Educational/Vocational Activities: MHD is in strong agreement with RSNs providing more educational and vocational assistance and opportunities for youth. More support to help children and youth stay in school, achieve decent þÿ g r a d e s , d e v e l o p m e a n i n g f u l a c t i v i t i e s , a þÿ t h e y g r o w - u p w i l l o n l y i n s t i l l h o p e f o r Resiliency.
þÿ "Evidence Based Practice: Training will continue to be offered around EBPs and research of promising best practices.

Washington

Child - Recent Significant Achievements

Child - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

The most significant event of this past year has been the initial steps toward implementation of the Children's Mental Health Act.

WrapAround pilot sites have been awarded in three RSNs. Readiness assessments have occurred in all three areas. Two of the three sites have had increased technical assistance on parent support and the creation of parent networks.

Additionally, this legislation called for:

- a review of the Access to Care Standards of children's mental health; preliminary work is completed on this review and the actuarial firm is producing a report.
- an increase provider network for the provision of 20 fee-for-service visits outside of the managed care system. To date 70 providers have signed contracts;
- Pilot for psychiatric consultation with Pediatricians for diagnosis and medication evaluations will be established with an overall reduction in psyche med under 5-years old and for those who cognitive therapies are indicated. A workgroup has been formed and has had 3 successful meetings.

Another highlight of legislation was the establishment of an EBP institute at the University of Washington division of public behavioral health and justice policy requires.

The institute has worked closely with the MHD in the implementation of the pilot sites and is preparing for the evaluation.

The Department of Social and Health Services including Mental Health Division, Juvenile Rehabilitation Administration (JRA) and the Children's' Administration (CA) and other state agencies have a number of initiatives to improve cross systems collaboration in an effort to enhance development of a comprehensive community-based mental health system specific to children and youth.

Governor Chris Gregoire announced an initiative to cover all children in the state with health insurance by 2010 early in her term of office. As part of the Health Care Services for Children Act, the 2007 Legislature approved new standards for Washington's public health coverage for children who live in families with incomes at up to two and half times the federal poverty level. The eligibility standards will increase in January 2009 to three times the Federal Poverty Level. At that point, parents in families with incomes above that ceiling will be able to buy coverage for their children by paying Medicaid's full cost of coverage. The new coverage, which will be consistent with Medicaid's traditional major medical coverage, includes medical, dental, and vision benefits. Families with incomes more than two times the Federal Poverty Level will pay a modest monthly premium ($15) for the coverage.

- EBPs are being implemented for children across the state.
    - Multidimensional Treatment Foster Care (MTFC)- 5 sites (MHD, CA and JRA)

- Trauma Focused Cognitive Behavioral Therapy (TF-CBT) – 41 sites in 13 RSNs
- Multi-systemic Treatment (MST) 4 sites (MHD, JRA)
- Family Integrated Transitions (FIT) 2 Sites (JRA)
- Functional Family Therapy (FFT) 2 Sites (JRA)
- Parent Child Interaction Therapy (PCIT)
- Dialectic Behavior Therapy (DBT) (MHD, JRA)
- Aggression Replacement Therapy (ART) (JRA)
- Multi-Family Group Family Psychoeducation (MFG) (MHD- CSTC**)**

Parents and youth continue to provide a strong voice to the Mental Health Transformation Workgroup and to the Division of Alcohol and Substance Abuse (DASA) Statewide Coordination Grant developing a statewide infrastructure that fosters cross system planning, knowledge and resource sharing to enhance the existing adolescent substance abuse treatment system.

In 2008, the MHD and the Mental Health Transformation project worked together with the Office of the Superintendent of Schools (OSPI) and an advisory group of mental health providers, educators and parents to develop and conduct statewide train- the-trainer sessions focusing on public education and publicly funded community mental health service coordination. One purpose was the development Response to Intervention strategies and practices specific to the mental well being of students. As this plan is being written, training is beginning to occur on that model.

Washington

Child - State's Vision for the Future

Child - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

þÿ T h i s i s a j o i n t r e s p o n s e . P l e a s e s e e A d u
However, to augment:

þÿ W a s h i n g t o n s R e c e n t S i g n i f i c a n t A c h i e v e m
examples of our future vision especially considering the legislation for children and the continued implementation of EBPs. Children are our future, and as such, they have an inherent right to experience an environment wherein everyone works collaboratively to ensure their well-being and their development as healthy and happy individuals. The Mental Health Division's goal is to see that children with SED are wholly supported, with all available resources, to become contributing members of society, where they can live, learn, and grow to their fullest potential. MHD is moving forward with the requirements to have in place by 2012 a "new" children's mental health system.

Washington

Adult - Establishment of System of Care

Adult - Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.

MHD is a division of the Health and Recovery Services Administration (HRSA) within the Department of Social and Health Services (DSHS). The Assistant Secretary of HRSA and the MHD Director are appointed by the Secretary of DSHS to oversee the MHD.

In 1989, the Washington State Legislature enacted the Mental Health Reform Act; a measure which consolidated responsibility and accountability for the provision and oversight of community mental health treatment with the creation of Regional Support Networks (RSNs). The RSNs are under direct contract with MHD to ensure quality outpatient services for individuals with mental illness, including crisis response and management of the involuntary treatment program. Within Pierce County the MHD contracts directly with the Community Mental Health Agencies for both state only and Medicaid services. Additionally, these contractors have special federal block grant contracts as do some smaller consumer and family operated businesses in the Pierce County system.

Beginning in October 1993, MHD implemented a capitated managed care system for community mental health services through a federal Medicaid waiver, thereby creating prepaid health plans operated by the Regional Support Networks.

The current community mental health system operates under the following Statutory authority:

- Chapter 10.77 RCW - Provides for the commitment of persons found incompetent to stand trial or acquitted of a crime by reason of insanity, when found to be a substantial danger to other persons or that there is a likelihood of committing acts jeopardizing public safety or security unless under control by the courts, other persons, or institutions. Also provides an indigent person's right to be examined by court appointed experts.
- Chapter 71.05 RCW - Provides for persons suffering from mental disorders to be involuntarily committed for treatment and sets forth that procedures and services be integrated with Chapter 71.24 RCW.
- Chapter 71.24 RCW - Establishes community mental health programs through regional support networks that operate systems of care.
- Chapter 71.32 RCW – Authorizes mental health advance directives.
- Chapter 71.34 RCW - Establishes mental health services for minors, protects minors against needless hospitalization, enables treatment decisions to be made with sound professional judgment, and ensures minors' parents/guardians are given an opportunity to participate in treatment decisions.
- Chapter 72.23 RCW - Establishes Eastern and Western psychiatric state hospitals for the admission of voluntary patients.
- Chapter 74.09 RCW - Establishes medical services, including behavioral health care, for recipients of federal Medicaid as well as general assistance and alcohol and drug addiction services.
- Chapter 38.52 RCW - Ensures the administration of state and federal programs for emergency management and disaster relief, including coordinated efforts by state and federal agencies; and,
- under a 1915b Medicaid waiver from the federal Centers for Medicare and Medicaid Services (CMS). The waiver allows the state to operate a managed care model.

In the last four-to-five years the system has undergone many changes. In 2005, the stage was set for change in Washington State in terms of the energy, discussion, and challenges that transpired related to our public mental health system through the following activities:

The creation of a legislatively mandated Mental Health Task Force (MHTF) charged with assessment of the mental health system and challenged to determine recommendations for improvements

In 2006 through direction and support of the state legislature the MHD conducted a RFQ/RFP process for its community services. Involvement of the MHTF continued through oversight of the procurement process.

Completion of the procurement process resulted in there being 13 RSNs. Two small RSNs in rural eastern Washington, Northeastern Washington RSN and North Central RSN are now combined as North Central RSN.

In 2008, Pierce County Officials chose not to contract with the state for mental health services. The MHD established a fee-for-service Medicaid system and contracted with the Community Mental Health Agencies in Pierce County to provide these services and the services required by the state. The CMHAs stepped up to the plate and consumers continued to receive services. The 2008 legislature established a process for the MHD to issue a RFP for another managed care entity for Pierce County with the contract beginning July 1, 2009.

Washington State continues to be proud to be one of the recipients of the Substance Abuse and Mental Health Services Administration's (SAMHSA) Mental Health Transformation System Improvement Grant (referred to as the Transformation Grant).

Under the guidance of Governor Christine O. Gregoire, Washington is demonstrating a firm commitment to all residents, both in policy and in practice, by dedicating the necessary resources, expertise, and visionary leadership toward a future where Transformation of the public mental health system becomes reality.

Washington

Adult - Available Services

Adult - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

Health, mental health, and rehabilitation services;
Employment services;
Housing
services;
Educational services;
Substance
abuse services;
Medical and dental services;
Support services;
Services provided by local school
systems under the Individuals with Disabilities Education Act;
Case management services;
Services
for persons with co-occurring (substance abuse/mental health) disorders; and
Other activities
leading to reduction of hospitalization.

The RSNs (and Pierce County Providers) responsibility for services is described in state statute RCW 71.24, 71.34, 71.05. These services include community support, employment, and residential services for persons meeting statutorily defined categories based on need. Community support services are described in Chapter 71.24 RCW but must cover at least the following six service areas:

- Emergency crisis intervention services;
- Case management services;
- Psychiatric treatment including medication supervision;
- Counseling and psychotherapy services;
- Day treatment services; and
- Consumer employment services.

With regard to residential and housing services, the Regional Support Networks must ensure:

- The active promotion of consumer access to, and choice in, safe and affordable independent housing that is appropriate to the consumer's age, culture, and residential needs.
- The provision of services through outreach, engagement and coordination or linkage of services with shelter and housing to families of eligible children and to eligible consumers who are homeless or at imminent risk of becoming homeless as defined in Public Law 100-77.
- The availability of community support services, with an emphasis on supporting consumers in their own home or where they live in the community, including a full range of residential services and residential supports described in the consumer's treatment plan.
- The eligible individuals residing in long-term care and residential facilities are apprised of their rights and receive mental health services consistent with their individual service plans.

RSNs and their sub-contracted licensed community mental health agencies coordinate with rehabilitation and employment services to assure that consumers who are able to work are provided with employment services. Case managers then assist consumers in achieving the self-determined goals articulated in their individual service plans by providing access to employment opportunities such as:

- A vocational assessment of work history, skills, training, education, and personal career goals;
- Information about how employment will affect income and benefits the consumer is receiving because of their disability;
- Active involvement with consumers served in creating and revising individualized job and career development plans;
- Assistance in locating employment opportunities that are consistent with the consumer's skills, goals, and interests;
- Integrated supported employment, including outreach/job coaching and

support in a normalized or integrated work site, if required; and
- Interaction with the consumer's employer to support stable employment and advise about reasonable accommodations in keeping with the Americans with Disabilities Act (ADA) of 1990, and the Washington State Anti-discrimination law.

All of the services outlined above are to be provided "within available resources," meaning all services may not be available in all areas of the state though efforts to expand "state-wideness" persist.

One of the difficulties is the fact that the RSNs are required to prioritize the expenditure of their state-only funds in covering the costs of crisis and ITA to all citizens of the state, of inpatient care for publically funded consumers, and residential resources.

Once those needs are met, an RSN may use the remaining funds on the other services above. Since inpatient services are some of the most costly to provide for the RSNs, significant effort has been made on the part of MHD to provide technical assistance to the RSNs on ways to improve their Utilization Management and Review tools and processes. RSNs are also encouraged to develop alternatives to their use of Institutions for Mental Disease (IMDs) as these may only be paid for through state only funds as well. Unfortunately, for some RSNs, their state-only funds are exhausted before they can get to the business of providing the other services listed above.

The mental health system and the RSNs operate the only behavioral health crisis system in the state, resulting in responsibility by default for conditions not normally considered as mental illness. These crisis services are available to anyone in the state, regardless of income.

Crisis services include a 24-hour crisis line and in-person evaluations for individuals requesting crisis intervention or for those individuals presenting with mental health crises. These situations are best resolved in the least restrictive manner and include family members and significant others as appropriate to the situation and as requested by the individual in need. For many consumers receiving services through the CMHAs, there is on file an Individual Crisis Plan (ICP). The ICP contains the preferred intervention strategies put forth by the consumer and their families. Further, many consumers also utilize Advance Directives for psychiatric care describing their desired outcomes should more restrictive measures be required to provide for their own safety or the safety of others. In addition, RSNs ensure access to other necessary services such as medical services and medication, interpretive services, staff with specialty expertise, and access to the involuntary treatment program.

Involuntary treatment services, as part of crisis services, are available in all of the communities of the state 24-hours per day. These services include a face-to-face evaluation of the need for involuntary psychiatric hospitalization. General criteria for such involuntary services include being determined by a Designated Mental Health Professional (DMHP) to be either gravely disabled or at risk of harm to self, others, or

property as a result of a mental disorder. Alone, neither risk of harm nor a mental disorder, are sufficient to justify the loss of an individual's right to make decisions about their own care. Further, the danger must be the result of the mental disorder. MHD has been given the authority to re-evaluate the laws that govern involuntary civil commitment this year and will do so with a cadre of partners.

While local decisions related to 72-hour involuntary detentions are made by community based DMHPs, state courts determine subsequent fourteen day or ninety day commitment decisions. Individuals needing involuntary care may receive it in community hospitals, in freestanding evaluation and treatment facilities, in one of the three state-operated psychiatric hospitals or in one of the three Children's Long Term Inpatient Residential Treatment Facilities for Psychiatrically Impaired Youth.

As a separate contract, the RSNs also operate as a prepaid inpatient health plan (PIHP) by administering a full continuum of community mental health services as defined in the Medicaid State Plan and Amendments (SPA) and as described in the 1915(b) waiver for managed care. A few of these services include:

- Comprehensive treatment activities (individual, group, family) designed to help the consumer attain goals as prescribed in the consumer's individual service plan. These services shall be congruent with the age and cultural framework of the individual and may be conducted with the consumer, his or her family, or others who play a necessary role in assisting the consumer to maintain stability in living, employment, or educational environments. These services may include, but are not limited to: developing the consumer's independent self care skills, monitoring and supervision of the consumer's functioning, health services, counseling, and psychotherapy.
- Appropriate prescription and administration of medications including responsible reviews of medications and their side effects and consumer/family education related to these.
- Effective hospital diversion services which are a less restrictive alternative to inpatient hospitalization, or are a transitional program after discharge from inpatient services. These services are designed for persons with serious mental disorders who require coordinated, intensive, comprehensive, and multidisciplinary treatment. These services include a mix of individual, group services, and crisis services.

As prepaid inpatient health plans, RSNs authorize and pay for voluntary community inpatient psychiatric care for residents in their service areas. As Medicare and private insurance continue to cut costs by trimming services and rates, community hospitals are examining their operations in order to eliminate or curtail services that are not cost effective. The result is that community hospitals are downsizing or threatening to close psychiatric wards. This situation is compounded by the fact that mental health costs grow at a rate higher than the state expenditure limit, similar to other health care costs.

Washington State continues to seek creative solutions to providing comprehensive medical services to all of our citizens. For the recipients of the public mental health system, this is usually through the base of community physicians who accept Medicaid for payment. There are also community clinics that provide service on a sliding scale basis for persons with limited resources. Case managers at the Community Mental Health Care Agency (CMHA) level, work with their respective consumers' Primary Care Physicians (PCP) to ensure physical issues are addressed.

While more needs to be done to improve the provision of health services to consumers with SMI, the state has implemented several strategies to address the over-arching access issue. For example, there are carve-out pilot programs in both Pierce County and King County that were developed to integrate primary care and substance abuse treatment. MHD's contracts with the Regional Support Networks (RSN's) and the Healthy Options Plans requires working agreements between these entities at the local level, detailing how they will coordinate care.

Effective January 2005, a pilot project was initiated called the Washington Medicaid Integration Project (WMIP). Through this project, DSHS has contracted with Molina Healthcare of Washington, Inc. (Molina) to manage and provide medical and chemical dependency services through Molina's provider network, with an initial requisite enrollment of 6,000 individuals in Snohomish County, though many people opted out of the program. The focus of this new project is to make available a care coordination model, which is a team of care coordinators who will work with the clients to help identify health issues early, help coordinate services, and help the client follow-through with prescribed treatment. Coordination of these services is expected to accomplish the following:

- Prevent unnecessary hospitalizations;
- Postpone placement in nursing homes;
- Eliminate duplicate prescriptions; and
- Prevent the use of emergency rooms for treating conditions that are more appropriately addressed in physicians' offices.

Outpatient mental health services are provided through Molina's approved network of providers consisting of licensed community mental health agencies. Together, all participants in WMIP are working to streamline and enhance the quality of care for Medicaid recipients enrolled in the pilot.

As with all health care, community based outpatient services are preferable when it comes to the diagnosis and treatment of health conditions. However, when acute situations arise or when outpatient services are unable to alleviate the presenting condition, inpatient hospital care often becomes a necessary and critical resource.

Dental services are available to adult consumers. However, it remains difficult to find dentists who accept medical coupons as payment and those that do, have very limited slots. The need to assess consumer's need for dental care is a requirement of the therapist

in developing an individual service plan. Several RSNs contract with SeaMar a FQHC to provide mental health services, a few SeaMar clinics have dental services available. Two RSNs are using flex funds for dental services for their clients.

Case Management services are required under RCW 71.24 and Washington Administrative Code 388-865-0230.

Co-occurring disorders for adults and youth were specifically addressed by the 2006 legislative session. Chapter 70.96 RCW requires that DSHS develop a plan for co-occurring mental health and substance abuse and by January 1, 2006 adopt a screening and assessment process for these individuals. The integrated process was implemented by all chemical dependency and mental health treatment providers as well as the designated mental health professionals and crisis responders on January 1, 2007. Training was provided to providers statewide on the implementation of the tool and the MHD staff participates on a co-occurring disorders advisory committee.

Several RSNs support education, employment, co-occurring and transition age youth activities through their federal block grant funds.

Washington

Adult - Estimate of Prevalence

Adult - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children

Based on the prevalence estimates provided in the Federal Register, Vol. 64, No. 121 Washington State has an estimated number of adults with serious mental illness (SMI) of 264,239. The Mental Health Division (MHD) has used the guidelines set forth in the Federal Register, Vol. 64, No. 121 to estimate the number of clients in our service population who have SMI. The MHD made operational the guidelines using diagnoses and the Global Assessment of Functioning (GAF). All diagnoses except substance abuse, development disorders, personality disorders, and dementia were used in the calculation. A GAF score of 60 or below was used as the functioning cutoff to determine SMI status. All numbers reported are based on data from fiscal year 2007.

Table 1: SMI Estimates for Adults (18 years or older)

Estimated SMI	Total Adults Served	Estimated SMI Served	Quantitative Target
264,239	84,271	64,216	50,000

Washington

Adult - Quantitative Targets

Adult - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1

The following tables include the actual number of adults (18+ years) served in FY2007 as well as the projected number served in FY2008. This information is reported for adults with serious mental illness and for the total adult service population. Washington State is not restricted in serving only clients with serious mental illness, although, the majority of the Mental Health Division service population meets the Federal Register criteria for serious mental illness.

In reviewing this table, please remember that these numbers represent Washington's best estimate for quantitative targets. Any data in the Adult Plan represents our best estimates based on available data and reflects the limitations of our reporting and information systems.

The following table provides the number of adults served with Serious Mental Illness and the total number of adults served. Then, by using an estimate of the number of people in Washington State with Serious Mental Illness and the total population, prevalence rates are reported for the State.

Fiscal Year 2008 projected service numbers are based on the most recent estimated population change data supplied by Washington State's Office for Financial Management (OFM) which are based on projections created from the most recent US Census. In 2007, the estimated adult population was 4,921,600 and the projected population for 2008 is not yet released.

Projected Service Rates				
Time Period	**FY07 Adults Served**		**FY08 Adults Projected**	
SMI Status	**SMI**	**Total**	**SMI**	**Total**
Adults Served	**64,216**	**84,271**	**60,938**	**79,865**
WA Adult Population	**264,239**	**4,921,600**	**Data not available**	**Data not available**
Penetration Rate	**24.3% of adults with SMI are served by the Mental Health Division**	**1.7% of all adults in Washington State are served by the Mental Health Division**		

This table shows that the Mental Health Division serves 24.9% of the adults in Washington State who are estimated to have a Serious Mental Illness and 1.7% of the general adult population. Adults with mental illness may be receiving services from private providers or through other systems, such as the VA system.

Washington

Adult - Outreach to Homeless

Adult - Describe State's outreach to and services for individuals who are homeless

For the past five (5) years, MHBG funds have been used to support several facilitated planning sessions in various parts of the state. For FFY2009 MHD made homelessness a priority for the federal block grant funds. Common Ground, a well established private, non-profit housing specialty agency, has conducted the planning sessions in RSNs designated by the state PATH contract. The planning sessions have occurred primarily in locations where there was no current PATH project. Common Ground is also working with the STI to develop the housing plan.

MHBG funds were used to support the annual Washington State Coalition for the Homeless state conference in 2008 and will do so again in 2009. PATH recipients and others who serve homeless, mentally ill people received financial assistance to support their attendance at the conference.

As a recipient of PATH grant funds and with additional SAMHSA technical assistance, Washington has also been involved in promoting SSI/SSDI Outreach Access and Recovery (SOAR) for the last year and a half. Through a contract with the state Department of Veteran's Affairs SOAR training has been provided to homeless providers and technical assistance to people serving persons who are homeless and mental illness. The training includes assistance on how to help people apply for benefits, disability insurance, Veteran's assistance and related services.

In FFY09, MHD plans on delivering the SOAR training to RSNs and other community providers so they may learn to assist more potentially eligible people to access benefits, speeding up the process and promoting the number of applications approved on first submission. Nationally, it takes close to a year to apply for benefits, and the first application is denied about 60 to 75% of the time. MHD hopes that with training we can reduce this percentage.

The RSNs are required through contract to provide jail coordination services. The following terms are included in the contract.

- Coordinate with local law enforcement and jail personnel including the maintenance or development and execution of Memorandum of Understandings with local county and city jails in the Contractors' service area which detail a referral process for persons who are incarcerated and diagnosed with a mental illness or identified as in need of mental health services.
- Identify and provide transition services to persons with mental illness to expedite and facilitate their return to the community.
- Accept referrals for intake of persons who are not enrolled in community mental health services but who meet priority populations as defined in RCW 71.24.
- Conduct mental health intake assessments for these persons and when appropriate provide transition services prior to their release from jail.
- Develop and execute a Memorandum of Understanding with local community service offices (CSO) for expedited application or reinstatement of medical assistance for individuals in jails, prisons, or IMDs.
- Assist individuals with mental illness in completing and submitting applications for medical assistance to the local CSO prior to release from jail.

After providing the services above the RSN may use the Jail Coordination Services funds provided to facilitate any of the following activities if there are sufficient resources:

- Daily cross-reference between new bookings and the RSN data base to identify newly booked, persons known to the RSN;
- Development of individual alternative service plans (alternative to the jail) for submission to the courts.
- Pre-release transition planning (e.g. assessments, mental health services, co-occurring services, and housing);
- Intensive post-release outreach to ensure there is follow up with the CSO and appointments for mental health and other services (e.g. substance abuse);
- Inter-local agreements with juvenile detentions facilities;
- Provision of up to a seven day supply of medications prescribed for the treatment of mental heath symptoms following the release from jail.
- Training to local law enforcement and jail services personnel; and
- Provision of direct mental health services to individuals who are in jails that have no mental health staff.

RSNs use federal block grant funds to provide homeless outreach, rent subsidies and support services, supported housing and transitional housing for young adults.

The last estimate of persons who are homeless and have a mental illness was completed in 2003. MHD is working with the Department of Health to update this number for 2009.

Although PATH funding is targeted to outreach and engagement of seriously mentally ill, homeless adults, the broader range of services listed below are integrated and augmented with additional local funds:

- Outreach and Engagement
- Screening and Diagnostic Treatment
- Habilitation and Rehabilitation
- Community Mental Health Services
- Alcohol or Other Drug Treatment
- Staff Training
- Case Management Services
- Referrals for Primary Health Services, Education Services, Job Training, and Housing Services
- Technical assistance in applying for housing

Washington

Adult - Rural Area Services

Adult - Describes how community-based services will be provided to individuals in rural areas

While 80% of the population resides on the Western half of the state, Washington has many rural areas within that populous as well as the on the less populated eastern side of the state.

Transportation is one of the larger barriers to accessing services but also the availability of treatment. Of course some of the more discrete issues are a culture of intense privacy, lack of trust for government, and increased isolation.

Some of the ways in which MHD has addressed the need for rural outreach has been by setting travel standards for accessing services, supporting training activities on the specialized needs of consumers in these less populated areas, and participating in the rural mental health conferences. One tool available for increased access to rural consumers is the use of telemedicine sites for the provision of services. Across the rural areas of Washington, there are several sites that are using this technology to access psychiatrists and other specialists for their clients.

While Washington has made significant progress in services to rural consumers, more needs to be done. Specifically, MHD wants to focus on:

þÿ "Increased education and training related to the special needs of this population and effect ways in which to engage them in treatment;
þÿ "Increased efforts to train providers on how to better assist these individuals in accessing the services for which they are eligible, such as Medicaid and Social Security Disability;
þÿ "Continued participation in the Rural Mental Health Conferences;
þÿ "Workforce development;
þÿ "Reducing stigma; and
þÿ "Increased demands for measurable outcomes that demonstrate consistency across population densities and age span.

Washington

Adult - Older Adults

Adult - Describes how community-based services are provided to older adults

Many issues exist with the provision of mental health services to older adults. The public testimony provided to the transformation group as part of their year one activities identified the following information:

- Older adults do not seek treatment and they also often refuse treatment when offered.
- Residential services and adult family homes are noted as working well for older adults but there are inadequate resources. The mental health system requires increased partnerships with providers of long-term care services including skilled nursing facilities, adult family homes and boarding homes.
- Intake and outreach procedures are not specific to older adults.
- A need for increased communication between physical health care providers, mental health care providers and other services older adults may be utilizing.
- A need for more workforce development in the field of geriatric mental health.

Older adults were another priority called out by the MHD for FFY09 federal block grant funding.

The Older Adults and Family and Treatment subcommittee (OATS) of the MHPAC envisions a system that encompasses cross-system coordination and prioritizes the development and implementation of policies, planning and evidence-based and promising practices that support the specialized needs of older adults. OATS is sponsoring a conference focusing on Older Adult issues September 16th. It's called "Promoting Resiliency with Older Adults". . This is the first conference of this kind for many years. Additionally, OATS will be the featured subcommittee at the MHPACs all stakeholder meeting in September.

Washington State is proud to be the founder of the Gatekeeper Program and continues to support this program. This program trains every day workers to recognize signs of isolation, depression and other age-related changes in older adults, as well as co-occurring substance abuse issues. MHD with assistance from OATS will work to reinvigorate this model across the state, currently there are only two active programs.

There are many other integrated and cross-system partnerships in the RSNs such as Elder Services, Expanded Community Services, Luckett House and Hope Options. The evidence based practices of PEARLS (Program to Encourage Active Rewarding Lives for Seniors) and IMPACT (Improving Mood and Promoting Access to Collaborative Treatment) for late life depression exist in a few CMHAs. MHD will support workforce development through training on these to collaborative care models.

Through the work of the STI benefit design, ITA review and housing plan it is anticipated the needs of older adults will be addressed by:

- Increased education and training related to the special needs of this population and effect ways in which to engage them in treatment;
- Increased efforts to train providers on how to better assist these individuals in

accessing the services for which they are eligible, such as Medicaid and Social Security;
- Continued workforce development
- Reducing stigma; and
- Increased understanding of designated mental health professionals and crisis workers on the needs of older adults.

Besides the Gatekeeper program, another innovative program is the Senior Services of Snohomish County. This program provides well-trained volunteers over age 55 to support residents age 60 and over in congregate care facilities or adult family homes. The program provides ongoing follow-up and small support groups around mental health issues.

In FFY 09, the RSNs will use MHBG funds for older adults in the following manner:
- Geriatric crisis services providing specialized out-of-facility services to older adults not on Medicaid to assist them to live as independently as possible and thereby promote resiliency;
- Gatekeeper program;
- Increased access to community support service by case finding and referral;
- Depression screening for older adults (60+) using the Geriatric Depressions Scale;
- HOPE Options an in-home intervention and case management service to vulnerable seniors with mental illness whose housing and independent lifestyle has become unstable; and
- Geriatric outreach and mental health screening.

Washington

Adult - Resources for Providers

Adult - Describes financial resources, staffing and training for mental health services providers necessary for the plan;

Each RSN is a county or group of counties. Some counties within the RSNs have specific taxes dedicated to mental health. These are Spokane, King, Island, Kitsap, Snohomish, Clark, Okanogan, Clallam, Skagit and Jefferson. These tax dollars are outside of the scope of the public mental health system administered by the MHD. They do use these tax dollars for specific mental health projects. Several RSNs contribute local funds as part of their matching dollars for their capitation medicaid payment.
The community mental health providers also have available donation and other funds that they use for non-medicaid consumers.

The spreadsheet below are the funds distributed by the MHD.

RSN Estimated Revenues

Fiscal Year 2008 and 2009

	Fiscal Year 2008		**Fiscal Year 2009**		**2009 FBG**
RSN	Medicaid	Non Medicaid	Medicaid	Non Medicaid	
Chelan Douglas	5,554,079	2,569440	5,906,073	2,749,824	97,688
Clark	16,905,807	8,751,720	17,209,650	9,450,360	372,564
Grays Harbor	5,104,340	1,479,048	5,454,346	1,601,184	65,003
Greater Columbia	36,898,603	13,087,692	38,584,412	14,228,328	602,658
King	80,130,328	40,767,252	85,442,310	43,892,832	1,694,590
North Central	14,283,799	3,794,880	15,087,667	4,142,916	193,715
North Sound	36,350,666	23,268,108	41,146,056	25,057,380	980,670
Peninsula	17,343,106	7,308,264	17,808,060	7,914,660	313,379
Pierce County	35,071,374	18,581,220	37,492,096	19726387	714,197
Southwest	6,324,760	1,926,648	6,579,151	2,092,356	89,378
Spokane	31,394,736	9,500,508	31,079,408	9,732,396	409,774
Thurston Mason	13,179,031	6,858,612	13,875,627	7,350,924	262,411
Timberlands	6,343,417	2,028,720	6,660,116	2,207,784	90,763
Total	304,767,046	139,922,112	322,324,973	150,147,332	5,886,792

Note: Non Medicaid revenue also includes funding related to Double Staff Bill (SHB 1456), Direct Care Wage Increase, Expanding Community Services (ECS), PALS, PACT and Jail Services

The table above provides estimates of the amount of funding available through the state of Washington to each Regional Support Network (RSN) for State Fiscal Years 2008 and 2009 based upon funding distribution formulas.

Many RSNs apply for grants, partnering with counties or other community agencies to increase their resource base. Additionally, the Community Mental Health Agencies with whom they contract may apply for grants, partner with non-profit organizations or conduct other activities in support of enhancing their fiscal resources.

Funds can not be separated by age.

Washington

Adult - Emergency Service Provider Training

Adult - Provides for training of providers of emergency health services regarding mental health;

Many of the RSNs provide training to emergency room staff to help specifically identify mental health issues and to coordinate care with designated mental health professionals for community diversion.

Greater Columbia RSN is providing training to law enforcement, nursing staff and EMTs regarding what mental health is, what constitutes a crisis and when to call the crisis team. MHD will be watching the outcomes of this training to see if it can be duplicated in the other rural areas of the state. Other RSNs provide training to ER and EMT staff on recognition of mental illnesses.

Through the collaborative effort of MHD with the Division of Developmental Disabilities (DDD) yet another example of training provided to emergency and health providers is the Community Hospital MI/DD Training. Together, the Divisions are creating a training targeted to the community hospitals that serve persons with a dual diagnosis of mental illness and developmental disability on how to better understand, evaluate, triage, and treat this special population. Training is being provided to both Emergency Room staff as well as employees who would be providing inpatient treatment.

MHD is committed to providing training to the State's emergency and health providers. As the first responders, emergency and health providers being well trained and educated about persons with mental illness and available services will only help move our state toward Transformation.

RSNs partner with their local NAMI and law enforcement officials for the provision of the evidence based practice called Crisis Intervention Training (CIT).

As a community partnership between all law enforcement agencies, mental health providers, mental health advocacy groups, and consumers of mental health services and their families, communities which establish CIT programs do so with the following goals in mind:

- Increase the feeling of safety in the general community
- Increase law enforcement officer safety
- Increase mental health consumer safety
- Better prepare police officers to handle crises involving people with mental illness
- Make the mental health system more understandable and accessible to law enforcement officers
  - Supply law enforcement officers with the resources to appropriately refer people in need of care to the mental health treatment system
  - Improve access to mental health treatment in general and crisis care specifically for people who are encountered by law enforcement
- Collaboratively, make the mental health system responsive to law enforcement to the greatest extent possible with community resources
- Divert people with a mental illness who are in crisis from the criminal justice system whenever possible and collaboratively work with the court systems to reduce the incarceration rate of people with a serious mental illness who are in need of treatment when applicable

This training is a weeklong, 40-hour training. The course emphasizes that CIT is a partnership between law enforcement, the mental health system, mental health advocacy groups, and consumers of mental health services and their families. As such, trainers include representatives of all identified stakeholders. The intensive training provides a common base of knowledge about mental illness; a basic foundation from which officers can build. The course is not aimed at making CIT officers mental health professionals; however, it is intended to provide officers with skills to:

1. Recognize signs and symptoms of mental illness
2. Recognize whether those signs and symptoms represent a crisis situation
3. De-escalate mental illness crises
4. Know where to take consumers in crisis
5. Know appropriate steps in following up these crises such as: contacting case managers, other treatment providers, or providing referral information to mental health treatment agencies or advocacy organizations like the local NAMI chapter to consumers and family members.

The training emphasizes development of communication skills, practical experience and role-playing. Also officers are exposed to mental health professionals, consumers and family members both in the classroom and in the field during site visits.

The week long course includes an overview of mental illness from multiple perspectives: Persons with mental illness; Family members of loved ones with mental illness; and Mental health professionals.

These perspectives are provided by individual consumer and family presentations or by panels of several consumers or family members. Substantive amounts of interaction between CIT officers-in-training and mental health consumers and their families make the core training session very effective as the officers learn the following:

- Specific signs and symptoms of serious mental disorders.
- The kinds of disturbed behavior officers may see in people in a mental illness crisis should be emphasized.
- The common problem of co-occurring disorders including co-occurring substance abuse and mental illness, along with co-occurring developmental disability and homelessness.
- The influence of culture and ethnicity on the topic of mental health and how it is dealt with inside those cultures and ethnicities specific to the ethnic make up of the particular community wherein the training is being provided.

Emergency service training that seems to be forgotten until it is needed is occurring in Washington State is for disaster preparedness. The state Mental Health Authority has the responsibility to respond to the behavioral needs of the citizens in times of a disaster. The MHD has an appointed Mental Health Disaster Coordinator, and requires in the RSN

contracts that they not only designate a coordinator but that they have a plan with their county authorities that outline their roles. These plans are reviewed by the MHD.

MHD has developed training materials for disaster mental health counseling based on the SAMHSA model of intervention. Materials include a power point and appropriate hand outs. One-training was provided in 2008 to at least 25 individuals to test and evaluate the materials. Those materials were to be updated and more ongoing training to occur. However, we were interrupted by the December Storms, we will now update the materials with the feedback from the training and the lessons learned by our Disaster Outreach Workers in the field and will deliver training over the next-year as part of our preparedness.

As described earlier in this application, the state did have a Presidential Declared Disaster in December. The RSNs and the Community Mental Health Agencies in the affected areas stepped up to the plate and provide immediate services to the storm survivors. It was apparent that they understood their role and were ready to go. As the need for help was greater than the state resources, MHD applied for and received both and Immediate Services Grant and a Regular Services grant. This means that crisis counseling to storm survivors will be available up to the anniversary of the event. Governor Gregoire, Senator Murray, Senator Cantwell and local congressmen have visited the sites and have paid tribute to the Disaster Outreach Workers that are still providing crisis counseling in the areas most affected by the storms.

Washington

Adult - Grant Expenditure Manner

Adult - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved

Of the estimated 8.3 million dollars awarded to Washington State, 5% (grant limit) stays at MHD for administrative costs. Of the *remaining* 95%, legislation has required that 80% be distributed to the RSNs. The other 20% (approximately 1.5 million) is utilized by MHD for selected activities. In determining which initiatives would be funded this year, MHD followed the list of guiding principals developed in 2007 against which all proposals would be measured. To be funded as part of the 20%, activities must:

1. Be in concert with the National Outcome Measures and fall within the parameters of the MHBG assurances and requirements;

2. Work in tandem with the Division's Strategic Plan which has been updated in collaboration with the MHPAC to incorporate the ideals of "Achieving the Promise: Transforming Mental Health Care in America";

3. Hold meaningful and measurable outcomes that are in line with articulated consumer/family/youth voice;

4. Link well to other resources and Transformation activities;

5. Meet needs in the system that are not fulfilled elsewhere, allowing for minimal negative impact on other service agencies if funding is not approved; and

6. Align well with other Division initiatives or legislatively mandated expectations.

The 2009 focus for block grant funding is:

- Consumer, advocate, and family voice driven and promoted activities

- Older Adult

- Homeless population with mental illness (emphasis on children, youth and their families)

- Tribal supports that improve infrastructure and services to tribal communities

- MHPAC resources that ensure consumer participation continues to increase and that state-wide diversity is represented

The primary ways in which these have been supported include:

- Conferences such as those for co-occurring disorders, behavioral healthcare, foster care, early intervention, ethic minorities, and youth/parent advocacy.
- Trainings for issues or populations such as disasters, assisting consumers in applying for Medicaid, increasing housing access, implementation of evidence–based practices, targeted trainings for geriatric specialists, ethnic minority specialists, chemical dependency specialists, older adults, ombuds, and peer

support counselors as well as trainings for building and sustaining skills and obtaining and maintaining employment, including consumer-run organizations.

- Research and data collection on such things as evidence–based practices, promising and best practices, consumer satisfaction, club houses, and services to persons who are incarcerated or have co-occurring disorders.

FFY 2007 (appropriation)	FFY 2008 (estimate)
$8,339,200	**$8,339,200**

RSN	**80% to RSN Using Population Distribution**
Chelan Douglas RSN	97,688
Clark County RSN	372,564
Grays Harbor RSN	65,003
Greater Columbia RSN	602,658
King County RSN	1,694,590
North Central RSN	193,715
North Sound RSN	980,670
Peninsula RSN	313,379
Pierce County RSN	714,197
Southwest RSN	89,378
Spokane RSN	409,774
Thurston Mason RSN	262,411
Timberlands RSN	90,763
Total	5,886,792

Total MHBG Award	8,339,200
5% for MHD Admin.	(416,960)
20% of remaining 95% for MHD initiatives & support of MHPAC	(1,584,448)
80% of remaining 95% for RSNs	6,337,792
Minus Legislatively Mandated MIO CTP	(451,000)
Remaining Available to RSN	5,886,792

The process by which the RSNs receive funds for specific services through this grant is continuing to improve:

1. RSNs must submit plans that fall within the guiding principles and spending categories.

2. RSNs must submit a statement articulating how its proposed plan supports Transformation, Recovery, or Resiliency.

3. RSNs must submit evidence that their RSN Advisory Board was involved in the development or review of their plan.

4. A review team consisting of state MH Program, Fiscal, Monitoring, Quality Assurance and Improvement staff as well as members of MHPAC will assess each planned service to ensure it falls within the guiding principles, spending categories, and promotes services geared toward the promotion of Recovery and Resiliency or Transformation.

5. Feedback will be provided to RSNs and at the end of the process, fully executed contracts that hold a greater focus on Recovery and Resiliency or Transformation will be in place by the start of the Federal Fiscal Year.

Examples of some of the RSN proposed uses for FFY 2009 MHBG funding include, but are not limited to:

- Continuing Education and Employment Services to consumers
- Homeless Outreach
- Outreach to Older Adults
- Consumer advocate positions
- Housing subsidies
- Resource Center for non-Medicaid Consumers
- EBP trainings (e.g.: DBT, WrapAround)
- Community based services to consumers in rural areas
- Cultural competency training
- Development of consumer-run programs/ businesses and drop-in centers
- Creation of new residential and hospital diversion resources
- Support to NAMI
- Expansion of co-occurring disorder treatment
- Tribal Youth Suicide prevention
- Stigma reduction
- Development of Clubhouses
- Provision of *Recovery* and *Resiliency* trainings
- Scholarships for consumers to attend workshops and conferences
- Peer support counselor training
- Crisis Intervention Training for law enforcement
- Consumer and family education
- Integrated medical and mental health screenings
- Transition Services re: drug/mental health court, and chemical dependency

Table C. MHBG Funding for Transformation Activities
State: Washington

	Column 1	Column 2	
	Is MHBG funding used to support this goal? If yes, please check	If yes, please provide the *actual* **or** *estimated* amount of MHBG funding that will be used to support this transformation goal in FY	
		Actual	**Estimated**
GOAL 1: Americans Understand that Mental Health Is Essential to Overall Health	☒		1,521,296
GOAL 2: Mental Health Care is Consumer and Family Driven	☒		1,515,294
GOAL 3: Disparities in Mental Health Services are Eliminated	☒		826,488
GOAL 4: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice	☒		2,709,966
GOAL 5: Excellent Mental Health Care Is Delivered and Programs are Evaluated*	☒		876,080
GOAL 6: Technology Is Used to Access Mental Health Care and Information	☒		68,500
Total MHBG Funds	N/A	0	7,517,624

*Goal 5 of the Final Report of the President's New Freedom Commission on Mental Health states: Excellent Mental Health Care is Delivered and Research is Accelerated. However, Section XX of the MHBG statute provides that research … Therefore, States are asked to report expected MHBG expenditures related to program evaluation, rather than research.

Washington

Table C - Description of Transformation Activities

For each mental health transformation goal provided in Table C, breifly describe transformation activities that are supported by the MHBG. You may combine goals in a single description if appropriate. If your State''s transformation activities are described elsewhere in this application, you may simply refer to that section(s).

Goal 1: funding will be used for NAMI education, training, community education and outreach.

Goal 2: will include comsumer run activities, clubhouses, parent and youth support, wraparound flex funds for service, peer support activities

Goal 3 includes activities for Tribal entities, older adults, co-occurring disorders.

Goal 4: is for activities related to EBPs and promising practices across the lifespan.

Goal 6 funding will be used for teleconferening and telemedicaine.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	73,466	84,642	86,561	86,561	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: #1: Increase Access to Services for Adults with SMI

Target: Adults served through the public mental health system: 80,262 Basic Tables 2A and 2B in the URS will provide breakout by Age, Gender, and Race/Ethnicity.

Population: Adults with Serious Mental Illness- Note (criterion below is self populating for 3:Children's Services won't let input Criteria 1: Comprehensive Community–Based Mental Health Plan.)

Criterion: 2:Mental Health System Data Epidemiology
3:Children"s Services

Indicator: RSNs and MHD will work to increase the number of adults served through the public mental health system, with focus given to special populations.

Measure: Number of persons served through public mental health system (No Numerator of Denominator required).

Sources of Information: MHD-Consumer Information System (CIS).

Special Issues: This was a new measure and no target was set for FY2006. In previous plans, WA used a penetration rate rather than an actual count.
Starting in Calendar Year 2008, Pierce County discontinued to operate as the Regional Support Network (RSN). Instead, the region was converted to a fee for service program for Medicaid mental health services and direct provider contracts were established for the allocation of state funds for crisis, residential and evaluation and treatment services. Pierce service encounter data is submitted to MHD via different transactions.

FY2008 projected number: For the service encounter data missing between January and June of 2008 for Pierce County, we used the actual count of unique consumers served by Pierce RSN in the same time period in 2007.

Significance: This is a required National Outcome Measure (NOM). No Numerator or Denominator required. Goal supports New Freedom Commission (NFC) goal #4. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #4.

Action Plan: Support the growth of a culturally competent workforce by training those who serve the following special populations: Older Adults, American Indians, Alaska Natives and their communities, Ethnic Minorities, Sexual Minorities, Hearing Impaired, and Developmentally Disabled. Support activities geared toward helping consumers obtain eligibility for social services including mental health, physical health, and dental care. Support efforts to create Electronic Medical Records. Continue to collaborate with other agencies to better support consumers/families served by multiple agencies.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	7.85	6.39	7.40	7.40	N/A	N/A
Numerator	769	643	--	--	--	--
Denominator	9,793	10,065	--	--	--	--

Table Descriptors:

Goal: #2: Decrease percentage of persons who are readmitted to an inpatient setting within 30 days of discharge.

Target: The percentage of adults readmitted to any inpatient setting within 30 days of discharge – 7.4%

Population: Adults with Serious Mental Illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Regional Support Networks (RSNs) will minimize the percentage of adults who were discharged from a state hospital, community hospital, or freestanding evaluation and treatment facility and who were then readmitted to any of the inpatient settings within 30 days.

Measure: Numerator: Number of persons readmitted to any inpatient setting within 30 days of discharge
Denominator: Number of total discharges from any inpatient setting.

Sources of Information: MHD-Consumer Information System (CIS).

Special Issues: Starting in Calendar Year 2008, Pierce County discontinued to operate as the Regional Support Network (RSN). Instead, the region was converted to a fee for service program for Medicaid mental health services and direct provider contracts were established for the allocation of state funds for crisis, residential and evaluation and treatment services. Pierce service encounter data is submitted to MHD via different transactions.

The projected percentage for FY2008 did not include Pierce region 2008 data. Pierce data is not ready for reporting at the time this application is being prepared. The FY2006 and FY2007 data showed a declining trend for Pierce region in the readmission rate. In FY2007, for example, Pierce region had a readmission rate much below the state rate. The missing Pierce data in 2008 may have contributed to the somewhat higher state readmission rate from FY2007.

Significance: This is a required National Outcome Measure (NOM). No Numerator or Denominator required. Goal supports New Freedom Commission (NFC) goal #4. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #4Decreasing returns to hospitals demonstrates increased community tenure which evidences recovery and adequate community supports.

Action Plan: Establish appropriate use and capacity of state psychiatric hospitals and promote services delivered in community settings through support and development of hospital diversion residential resources in the community. Continue to require through contract that persons discharged from the state hospitals are seen within 7 days.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	22.88	23	23	N/A	N/A
Numerator	N/A	2,303	--	--	--	--
Denominator	N/A	10,065	--	--	--	--

Table Descriptors:

Goal: #3: Decrease percentage of persons who are readmitted to an inpatient setting within 180 days of discharge.

Target: The percentage of adults readmitted to any inpatient setting within 180 days of discharge – 23%

Population: Adults with Serious Mental Illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Regional Support Networks (RSNs) will minimize the percentage of adults who were discharged from a state hospital, community hospital, or freestanding evaluation and treatment facility and who were then readmitted to any of the inpatient settings within 180 days.

Measure: Numerator: Number of persons readmitted to any inpatient setting within 180 days of discharge
Denominator: Number of total discharges from any inpatient setting.

Sources of Information: MHD-Consumer Information System (CIS).

Special Issues: See notes about Pierce RSN in the Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days.

The projected percentage for FY2008 did not include Pierce region 2008 data. Pierce data is not ready for reporting at the time this application is being prepared. The FY2006 and FY2007 data showed a declining trend for Pierce region in the readmission rate. In FY2007, for example, Pierce region had a readmission rate much below the state rate.

Significance: This is a required National Outcome Measure (NOM). No Numerator or Denominator required. Goal supports New Freedom Commission (NFC) goal #4. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #4. Decreasing readmission to hospitals demonstrates increased ability to maintain community tenure which further evidences adequate community supports and increases the likelihood of recovery.

Action Plan: Establish appropriate use and capacity of state psychiatric hospitals and promote services delivered in community settings through support and development of hospital diversion residential resources in the community. Continue to require through contract that persons discharged from the state hospitals are seen within 7 days.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Supported Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	2,618	2,618	2,618	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To increase the number of adults who receive supported housing services.

Target: To increase the number of adults who receive supported housing services to 2,618.

Population: Adult with serious mental illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Increase the number of adults (18+) who receive supported housing services.

Measure: Number of adults (18+) who receive supported housing services.

Sources of Information: Provider survey conducted by the Washington Institute for Mental Health Research and Training (WIMHRT).

Special Issues: FY2008 data is not available at the time this application is being prepared.
The number of clients reported represent only the providers in the State who participated in the survey. It does not include consumers who receive the services throughout the State. Counts of the number of clients who receive supported housing services are provided by provider agency self-report on a survey. There is some question about whether the counts of clients who receive each EBP are overcounts. Also there is no way to unduplicate client counts across providers.

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Supported Employment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	1,872	1,872	1,872	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To increase the number of clients who receive supported employment

Target: The number of adults who receive supported employment service is 1,872.

Population: Adult with serious mental illness.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Number of clients who receive supported employment

Measure: Number of clients who receive supported employment

Sources of Information: Provider survey conducted by the Washington Institute for Mental Health Research and Training (WIMHRT).

Special Issues:

FY2008 data is not available at the time this application is being prepared.
See notes for Supported Housing indicator.

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Assertive Community Treatment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	782	782	782	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: #5: Increase the number of EBPs received by adults

Target: The number of clients who receive Assertive Community Treatment is: 782

Population: Adults with Serious Mental Illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Regional Support Networks (RSNs) and MHD will work to increase the number of adults receiving EBP treatment throughout the state.

Measure: Number of EBPs received by adult mental health consumers through out the state. (No Numerator or Denominator required)

Sources of Information: This is new data being acquired through a Provider Survey conducted by Washington Institute for Mental Health research and Training (WIMHRT).

Special Issues: FY2008 data is not available at the time this application is being prepared.
See notes for Supported Housing indicator.

Significance: This is a required National Outcome Measure (NOM). No Numerator or Denominator required. Goal supports New Freedom Commission (NFC) goal #5. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #5.

Action Plan: Support training across spectrum of administrators, providers, and consumer/family members related to the research, development, or movement of best practices to EBPs as well as implementation of EBPs that are culturally competent. Oversee the implementation of six (6) 2006 legislatively funded PACT Teams. Disseminate EBP Resource Guides. Support Mental Health Specialist.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Family Psychoeducation (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	5,976	5,976	5,976	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To increase the number of adults who receive Family Psychoeducation.

Target: The number of adults receiving Family Psychoeducation is: 5,976.

Population: Adults with serious mental illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Increase the number of adults who receive Family Psychoeducation

Measure: Number of adults who receive Family Psychoeducation services.

Sources of Information: Provider survey conducted by Washington Institute for Mental Health Research and Training (WIMHRT)

Special Issues: FY2008 data is not available at the time this application is being prepared.
See notes for Supported Housing indicator.

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Integrated Treatment of Co-Occurring Disorders(MISA) (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	3,045	3,045	3,045	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To incrase the number of adults who receive co-occurring disorders treatment

Target: The number of adults who receive co-occurring disorders treatment is: 3,045

Population: Adults with serious mental illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Number of adults who receive co-occurring disorders treatment

Measure: Number of adults who receive co-occurring disorders treatment

Sources of Information: Provider survey conducted by Washington Institute for Mental Health Research and Training (WIMHRT)

Special Issues: FY2008 data is not available at the time this application is being prepared.
See notes for Supported Housing indicator.

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Illness Self-Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	1,044	1,044	1,044	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To increase the number of adults who receive illness self-management services

Target: The number of adults who receive illness self-management services: 1,044

Population: Adults with serious mental illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Increase the number of adults who receive illness self-management services.

Measure: Number of adults who receive illness self-management services

Sources of Information: Provider survey conducted by Washington Institute for Mental Health Research Training (WIMHRT)

Special Issues: FY2008 data is not available at the time this application is being prepared.
See notes for Supported Housing indicator

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Medication Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	18,180	18,180	18,180	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To increase number of adults who receive medication management services

Target: The number of adults receiving medication management services is: 18,180

Population: Adults with serious mental illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Increase the number of clients who receive medication management services

Measure: Number of adults who receive medication management services

Sources of Information: Provider survey conducted by Washington Institute for Mental Health Research and Training (WIMHRT)

Special Issues: FY2008 data is not available at the time this application is being prepared.
See notes for Supported Housing indicator

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	59.17	55.18	60	60	N/A	N/A
Numerator	1,110	772	--	--	--	--
Denominator	1,876	1,399	--	--	--	--

Table Descriptors:

Goal: #6: Improve client perception of care.

Target: The percentage of adults who report achieving positive outcomes on the MHSIP Survey: 60%.

Population: Adults with Serious Mental Illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Regional Support Networks (RSNs) will work to improve client perception of care as evidenced by the number of adults surveyed who agree with the items on the MHSIP regarding their perception of positive outcomes.

Measure: Numerator: Number of persons who responded that they agreed or strongly agreed to the positive outcomes scale on the MHSIP survey. Denominator: Number of total MHSIP respondents.

Sources of Information: The MHSIP survey conducted by Washington Institute for Mental Health research and Training (WIMHRT).

Special Issues: In the past, WA has measured perception of care using a different scale on the MHSIP. Additionally, WA only conducted the Adult MHSIP every other year, with the off years being used to conduct youth surveys. Beginning with FY2007 application, however, the MHSIP has been conducted on a yearly basis for both populations, per SAMHSA requirements re: yearly reporting on this NOM.

Significance: This is a required National Outcome Measure (NOM). No Numerator or Denominator required. Goal supports New Freedom Commission (NFC) goal #4. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #4

Action Plan: Continue to support training across spectrum of administrators, providers, and consumer/family members related to articulated consumer/family voice. In particular, Recovery, Consumer Driven service system, and culturally competent care initiatives will be emphasized. OMBUDS training will also be supported.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Adult - Increase/Retained Employment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	10.60	11.57	11.60	11.60	N/A	N/A
Numerator	8,148	7,393	--	--	--	--
Denominator	76,863	63,921	--	--	--	--

Table Descriptors:

Goal: Increase the number of persons who are engaged in employment related activities.

Target: The percentage of adults who are employed is: 11.6%.

Population: Adults

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: Regional Support Networks (RSNs) will increase the percentage of adult outpatient recipients between 18 and 64 years of age who were engaged in employment at any time during the fiscal year.

Measure: Numerator: Number of adults (18-64) who were employed either part-time or full-time, in supported employment at any time in the fiscal year.

Denominator: Number of total adults who received MH services in the FY and whose employment status is available.

Sources of Information: MHD-Consumer Information Systems (CIS).

Special Issues: WA has lost funding through Division of Vocational Rehabilitation for support of Club Houses; however, MHD is seeking legislative funding to reinstate support of this pre-vocational program.

Significance: This is a recommended National Outcome Measure (NOM), in process of becoming required. Goal supports New Freedom Commission (NFC) goal #4. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #4

Action Plan: Continue to support training of certified peer counselors. Support efforts to train administrators and providers on value/ways of employing certified peer counselors. Support programs designed to facilitate return to school and competitive employment for consumers.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Adult - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	20.23	39.25	27.60	27.60	N/A	N/A
Numerator	26,300	42	--	--	--	--
Denominator	130,000	107	--	--	--	--

Table Descriptors:

Goal: Decrease the number of persons who have had criminal justice system involvement including arrest and incarcerations.

Target: Percent of adult consumers arrested in T1 who were not rearrested in T2 is: 27.6%.

Population: Adults

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: The percentage of adults who have had involvement with crimintal justice system in the fiscal year.

Measure: Prior to 2007: Numerator: Number of adults who were arrested, convicted, or adjudicated in the fiscal year.
Denominator: Number of total adults served by the mental health division in the fiscal year.
FY2007 and forward: Numerator: From the MHSIP survey the number of adults who responded they were arrested in the fiscal year.
Denominator: Number of adults who responded to the MHSIP survey and who reported being arrested in the previous year.

Sources of Information: Prior to 2007: Merge the MHD data with the State's arrest and conviction data.
FY2007 forward: Adult MHSIP survey conducted by Washington Institute for Mental Health Research and Training (WIMHRT).

Special Issues: Prior to 2007: MHD was not been able to obtain timely data due to system limitations. This is no longer an issue with the MHSIP survey beginning in 2007.

Significance: This is a recommended National Outcome Measure (NOM), expected to become required. Goal supports New Freedom Commission (NFC) goal #4. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #4

Action Plan: Continue to support training of Law Enforcement in EBP of Crisis Intervention Training (CIT). Continue to support persons served in Mentally Ill Offender program. Continue to require, through State Mental Health contract, the provision of Jail Transition Services, required by 2006 legislative budget proviso including assistance with applications to Medicaid. Support outcomes of Safety Summits. Assess ability to improve more timely data collection for this NOM. This data will be collected on the MHSHIP Survey or on annual basis using the questions and methodology proposed by SAMHSA.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Adult - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	90.65	90.50	90.50	N/A	N/A
Numerator	N/A	50,305	--	--	--	--
Denominator	N/A	55,491	--	--	--	--

Table Descriptors:

Goal: Increase/Maintain family stability as evidenced by adults maintaining housing.

Target: The percentage of adults (18+) who maintain housing in the fiscal year is 90.5%

Population: Adults

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Percentage of adults (18+) who maintain housing in the fiscal year

Measure: Numerator: Number of adults (18+) who maintain housing in the fiscal year
Denominator: Number of total adults receiving outpatient services and who had more than one living situation recorded in the fiscal year

Sources of Information: MHD's Consumer Information System (CIS)

Special Issues: Stable housing continues to be a real and serious challenge for WA; however, MHD remains committed to encouraging growth of appropriate residential resources and supports through the RSNs.

FY2008 projected percentage did not include Pierce region 2008 data. See notes about Pierce County in "Increase Access to Services" indicator.

Significance: Goal supports New Freedom Commission (NFC) goal #3.

Action Plan: Continue to support development residential resources and encourage the development of safe, affordable housing. Continue to support mental illness education, stigma reduction, recovery, resiliency, employment and other factors that lead to stable housing. Continue to require and further encourage development of cross-system collaboration efforts for families served by multiple agencies within DSHS and the community.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Adult - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	62.21	63	63	N/A	N/A
Numerator	N/A	889	--	--	--	--
Denominator	N/A	1,429	--	--	--	--

Table Descriptors:

Goal: Increase the number of social and natural supports reported by consumers.

Target: The percentage of adult consumers who report they are socially connected is 63.

Population: Adults

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: RSNs will work to assist adult consumers in increasing their social and natural supports.

Measure: Numerator: Number of adults who responded Agree and Strongly Agree to the MHSIP Social Connectness scale in the FY.
Denominator: Number of total adults who responded to the MHSIP survey in a fiscal year.

Sources of Information: Beginning in 2007, MHD is using the MHSIP survey for this indicator.

Special Issues:

Significance: This is a recommended National Outcome Measure (NOM), expected to become required. Goal supports New Freedom Commission (NFC) goal #1 & #5. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #1 & #5. Having meaningful relationships is a necessary part of increasing likelihood of recovery.

Action Plan: Continue to support drop-in centers, consumer and family advocacy/self-help, social activities, pre-vocational skill building, and development of ICCD Club Houses through trainings across spectrum of administrator, providers, consumers and family members. Continue to require through contract that consumer's are informed of their right to have and are encouraged to have family/friends involved in their Recovery plan/treatment. Continue to support Tribal activities that enhance that community's whole-wellness. Support Mental Illness Education and Stigma Reduction activities

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Adult - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	61.68	65	65	N/A	N/A
Numerator	N/A	874	--	--	--	--
Denominator	N/A	1,417	--	--	--	--

Table Descriptors:

Goal: : Improve level of functioning.

Target: The percentage of adult consumers who report positively on the functioning scale of the MHSIP survey is 65%.

Population: Adults

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services
4:Targeted Services to Rural and Homeless Populations

Indicator: RSNs will work to increase the number of adults and older adults who report improved level of functioning over a fiscal year.

Measure: Numerator: Number of adults who responded Agree and Strongly Agree with the MHSIP Functioning scale.
Denominator: Number of total adults who responded to the MHSIP survey in a fiscal year.

Sources of Information: Adult MHSIP survey conducted by Washington Institute for Mental Health Research and Training (WIMHRT). The functioning scale consists of 6 items.

Special Issues:

Significance: This is a recommended National Outcome Measure (NOM) expected to become a required. Goal supports New Freedom Commission (NFC) goal #5. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #5. Being involved in meaningful activities is a necessary part of increasing potential for recovery.

Action Plan: Continue to support quality improvement as it relates to services for adult consumers since symptom reduction and involvement in meaningful activities are conversely related. Support consumer participation in activities that enhance creativity, spirituality, education, employment, social interaction.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: 1.07. Increase in Employment or Return to School - Adult

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	10.60	15.36	N/A	N/A	N/A	N/A
Numerator	8,148	221	--	--	--	--
Denominator	76,863	1,438	--	--	--	--

Table Descriptors:

Goal: #7: Increase the number of persons who are engaged in employment related activities or attending school.

Target: This will be reported as one of the NOMs indicators in FY2008 and forward.

Population: Adults with Serious Mental Illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: 1.08. Decrease Criminal Justice Involvement - Adult

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	20.20	N/A	N/A	N/A	N/A	N/A
Numerator	26,300	N/A	--	--	--	--
Denominator	130,000	N/A	--	--	--	--

Table Descriptors:

Goal: #8: Decrease the number of persons who reported being arrested in the FY.

Target: This will be reported as one of the NOMs indicators in FY2008 and forward.

Population: Adults with Serious Mental Illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance: This is a recommended National Outcome Measure (NOM), expected to become required. Goal supports New Freedom Commission (NFC) goal #4. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #4

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: 1.09. Increase Social Supports - Adult

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: #9:

Target: This will be reported as one of the NOMs indicators in FY2008 and forward.

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: 1.10. Increase Family Stabilization/Living Conditions - Adult

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	63.80	N/A	N/A	N/A	N/A	N/A
Numerator	54,003	N/A	--	--	--	--
Denominator	84,625	N/A	--	--	--	--

Table Descriptors:

Goal: #9: Increase family stabilization as evidenced by consumers maintaining housing.

Target: This will be reported as one of the NOMs indicators in FY2008 and forward.

Population: Adults

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance: This is a recommended National Outcome Measure (NOM), expected to become required. Goal supports New Freedom Commission (NFC) goal #1 & #3. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #1 & 3. Having meaningful relationships is a necessary part of increasing likelihood of recovery.

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: 1.11. Improved Level of Functioning - Adult

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: #11: Improve level of functioning as evidenced by increased involvement in meaningful activities.

Target: This will be reported as one of the NOMs indicators in FY2008 and forward.

Population: Adults with Serious Mental Illness

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance: This is a recommended National Outcome Measure (NOM) expected to become a required. Goal supports New Freedom Commission (NFC) goal #5. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #5. Being involved in meaningful activities is a necessary part of increasing potential for recovery.

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑☐

Name of Performance Indicator: 5.1 Critical Incident Training

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	5	5	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: #1: To improve First Responders' abilities to identify and interact with mental health consumers.

Target: Washington will complete CIT training program.

Population: Adults, Children and Youth with Serious Emotional Disturbance.

Criterion: 5:Management Systems

Indicator: Complete the CIT training models and curriculum.

Measure: The CIT Training Program will be used by one pilot site in 2008.

Sources of Information: MHD self report.

Special Issues: This program is accomplished in a variety of ways with a variety of community members. MH Transformation Project is working to develop standardized curriculum. Stakeholder comment could delay implementation.

Significance: MHD is committed to improving the quality of services supported through MHBG funding, and is supportive of standardized programming statewide.

Action Plan: Continue to support ongoing training and monitoring of outcomes; updating training for those first responders who have completed various trainings across the state with the goal of a standardized model by 2010.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: 5.1 Research and Quality Improvement

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: #1: Improve quality of services supported with MHBG funds.

Target:

Population:

Criterion: 5:Management Systems

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan: Continue to support quality review and improvement activities including consumer/family surveys, MHBG Peer Review, support of Consumer, Youth, and Family Network, research and training on EBPs and quality Review team. Continue to increase focus on contract monitoring and compliance.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: 5.2 Workforce Development

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: #2: Develop and enhance highly skilled workforce.

Target:

Population:

Criterion: 5:Management Systems

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan: Continue to support MHPAC activities including opportunities for attend national conference. Continue to support MHD staff training opportunities as well as Emergency/Disaster Preparedness. Focus will also be on trainings in Recovery and resiliency, EBPs, cultural competency, housing, employment, and safety.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑☐

Name of Performance Indicator: 5.3 Recovery-Oriented System of Care

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: #3: Facilitate growth of Recovery-Oriented system of care

Target:

Population:

Criterion: 5:Management Systems

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

Washington

Child - Establishment of System of Care

Child - Provides for the establishment and implementation of
an organized community-based system of care for individuals with mental illness.

This is a joint response. þÿ P l e a s e s e e A d u l t E s t a b l i s

However, it is important to note increased attention to children's mental health and the passage the Children's Mental Health Act and the pilots for Evidence Based and Promising Practices will lead to an enhance service package for children, youth and their families.

Last year, the MHD employed approximately 60 persons at headquarters and approximately 240 are at Child Study and Treatment Center. These numbers do þÿ n o t c o u n t t h e f i s c a l , I T a n d c o n t r a c t s t in HRSA. Our fiscal, contract and IS staff have all been allocated as shared services.

The MHD headquarters staff is responsible for program and planning, licensing and certification of Community Mental Health Agencies (there is one children's mental health specialist on the licensing team), contract monitoring and federal program development. Within the specialty programs are employees as children's mental health (3 FTEs and 1 parent liaison), an ethnic minority specialist (also covering children and youth issues).

Staff in headquarters also oversee the crisis programs, co-occurring illnesses with developmental disabilities and substance abuse, , the jail programs and sit on a variety of cross-system or interagency committees relating to children, youth and their families.

Washington

Child - Available Services

Child - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

Health, mental health, and rehabilitation services;
Employment services;
Housing
services;
Educational services;
Substance
abuse services;
Medical and dental services;
Support services;
Services provided by local school
systems under the Individuals with Disabilities Education Act;
Case management services;
Services
for persons with co-occurring (substance abuse/mental health) disorders; and
Other activities
leading to reduction of hospitalization.

Services available to children and youth consumers include the full scope of Medicaid Rehabilitative services as described in the State Plan services which include:

- Brief Intervention Treatment;
- Crisis services;
- Day Support;
- Family treatment;
- Freestanding Evaluation and Treatment;
- Group treatment services;
- High Intensity Treatment;
- Individual Treatment Services;
- Intake evaluation;
- Medication Management;
- Medication Monitoring;
- Mental Health Services provided in Residential settings;
- Peer Support;
- Psychological Assessment;
- Rehabilitation Case Management;
- Special population evaluation;
- Stabilization Services; and,
- Therapeutic psychoeducation.

The following EBPs are available in various communities across the state and offer support, social supports, and diversion from hospital or out-of-home placement.

- Multidimensional Treatment Foster Care (MTFC)- 5 sites (MHD, CA and JRA)
- Trauma Focused Cognitive Behavioral Therapy (TF-CBT) – 41 sites in 13 RSNs
- Multi-systemic Treatment (MST) 4 sites (MHD, JRA)
- Family Integrated Transitions (FIT) 2 Sites (JRA)
- Functional Family Therapy (FFT) 2 Sites (JRA)
- Parent Child Interaction Therapy (PCIT)
- Dialectic Behavior Therapy (DBT) (MHD, JRA)
- Aggression Replacement Therapy (ART) (JRA)
- Multi-Family Group Family Psychoeducation (MFG) (MHD- CSTC)

Last year, the MHD employed approximately 60 persons at headquarters and nearly 1,700 persons at the state hospitals. Approximately 240 of the hospital staff are at Child Study and Treatment Center. These numbers do not count the fiscal, IT and contract staff that are part of "shared-services" in HRSA. Our fiscal, contract and IS staff have all been allocated as shared services.

The MHD headquarters staff is responsible for program and planning, licensing and certification of Community Mental Health Agencies, contract monitoring and federal program development. Within the specialty programs are employees as children's mental health (3 FTEs and 1 parent liaison), an ethnic minority specialist (also covering children and youth issues).

Staff in headquarters also oversee the crisis programs, co-occurring illnesses with developmental disabilities and substance abuse, , the jail programs and sit on a variety of cross-system or interagency committees relating to children, youth and their families.

RSNs work collaboratively with their local schools, fund some projects with FBG funds to enhance children's success in school or in after school programs. SAFE-WA has had initial contact with OSPI to begin a collaborative working relationship with the parent groups active in their Readiness to Learn Projects. This relationship will develop more in the 2009 funding cycle increasing the parent support activities for parents of children with SED.

Children and youth who are Medicaid enrollees also have the added services provided under EPSDT. This allows for a coordinated system of care between primary care, mental health, substance abuse, dental, hearing and vision. HRSA hosts an EPSDT improvement team quarterly to increase the utilization of EPSDT.

An innovative program is the Access to Baby and Child Dentistry. This initiative is to increase access to dental services for Medicaid eligible infants, toddlers and preschoolers.

Co-occurring services are required for youth through RCW 70.96 which was described in the Adult plan. This requires screening and assessment to identify the most common types of co-occurring disorders. Training occurred statewide on the GAIN-SS and use of the tool began in January 2007.

Children and youth have the same services available to them as adults and older adults such as: crisis, ITA, case management, community outpatient and inpatient services. In addition, the RSNs provide many coordinated services supporting resiliency and transformation through their federal block grant funds to children, youth and their families. A few are listed below:

- Tribal youth suicide prevention
- Peer support
- NAMI parent to parent training
- Suicide prevention training
- WrapAround training
- Parent Partner activities
- Psychiatric evaluation and medication management for SED youth not covered by Medicaid
- Children's crisis outreach
- October 2009 specialist conference to develop standards
- Parent education
- Underinsured school age children with counseling services
- Children's mental health specialist training
- Day support program in the school
- Parent ran organizations

- EBP implementation for the Tribes

As a community partnership between law enforcement agencies, mental health providers, mental health advocacy groups, and consumers of mental health services and their families, communities which establish CIT programs do so with the following goals in mind:

- Increase the feeling of safety in the general community
- Increase law enforcement officer safety
- Increase mental health consumer safety
- Better prepare police officers to handle crises involving people with mental illness
- Make the mental health system more understandable and accessible to law enforcement officers
    - Supply law enforcement officers with the resources to appropriately refer people in need of care to the mental health treatment system
    - Improve access to mental health treatment in general and crisis care specifically for people who are encountered by law enforcement
- Collaboratively, make the mental health system responsive to law enforcement to the greatest extent possible with community resources
- Divert people with a mental illness who are in crisis from the criminal justice system whenever possible and collaboratively work with the court systems to reduce the incarceration rate of people with a serious mental illness who are in need of treatment when applicable

The week long course includes an overview of mental illness from multiple perspectives: Persons with mental illness; Family members of loved ones with mental illness; and Mental health professionals. Several parents of youth and youth in transition have become involved with the CIT training and have been making an impact on the understanding of the needs of youth living with SED.

Washington

Child - Estimate of Prevalence

Child - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children

Based on the prevalence estimates provided in the Federal Register, Vol. 64, No. 121 Washington State has an estimated number of children with serious emotional disorders (SED) between **70,619 and 86,312**. The Mental Health Division (MHD) has used the guidelines set forth in the Federal Register, Vol. 64, No. 121 to estimate the number of children in our service populations who have SED. The MHD operationalized the guidelines using diagnoses and the Children's Global Assessment Scale (CGAS). All diagnoses except substance abuse and development disorders were used in the calculation. A CGAS score of 60 or below was used as the functioning cutoff to determine SED status. All reported numbers are based on data from fiscal year 2007.

Table 2: SED Estimates for Children (0-17 years of age)

Estimated SED	Total Children Served	Estimated SED Served	Quantitative Target
70,619-86,312 – 92,911	35,109	29,000	27,000

Washington

Child - Quantitative Targets

Child - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1

The following tables include the actual number of children/youth (0-17 years) served in FY2007 as well as the projected number served in FY2008. This information is reported for children/youth with serious emotional disorders and for the total child/youth service population. Washington State is not restricted in serving only clients with serious mental illness, although, the majority of the Mental Health Division service population meets the Federal Register criteria for serious mental illness.

In reviewing this table, please remember that these numbers represent Washington's best estimate for quantitative targets. Any data in the Children's Plan represents our best estimates based on available data and reflects the limitations of our reporting and information systems.

The following table provides the number of children/youth served with Serious Emotional Disorders and the total number of children/youth served. Then, by using an estimate of the number of children/youth in Washington State with Serious Emotional Disorders and the total population, prevalence rates are reported for the State.

Any data in the Child Plan represents our best estimates based on available data and reflects the limitations of our reporting and information systems. FY 2008 projected prevalence rate is not yet available.

Projected Penetration Rates				
Time Period	**FY07 Served**		**FY08 served**	
SMI Status	**SED**	**Total**	**SED**	**SED**
Children Served	**29,000**	**35,009**	**24,141**	**32,265**
WA Child/Youth Population	**70-619-86,312**	**1,566,400**	**not available**	**not available**
Penetration Rate		**2.4% of all children/youth in Washington State are served by the Mental Health Division**		

Washington

Child - System of Integrated Services

Child - Provides for a system of integrated services appropriate for the multiple needs of children without expending the grant under Section 1911 for the fiscal year involved for any services under such system other than comprehensive community mental health services. Examples of integrated services include:

Social services;
Educational services, including services provided under the Individuals with Disabilities Education Act;
Juvenile justice services;
Substance abuse services; and

Health and mental health services.

Public mental health services are provided to children and youth under the same Regional Support Network managed care system as the adults. Each RSN is required to hold Memorandums of Understanding with the allied systems of care related to children and youth in their regions. Emphasis is given to the expectation that services for children will be well coordinated on every level. As per SAMHSA requirement, MHBG funds are not expended to provide any services other than comprehensive community mental health services.

Services for children and youth are integrated throughout the mental health system and allied system of care and are available statewide. The RSNs are responsible for coordinating the care of children and youth served by multiple systems such as substance abuse, developmental disabilities, juvenile corrections, child welfare, Medicaid-funded healthcare, and the schools. The RSNs and their providers utilize multidisciplinary teams to coordinate care. A growing percentage of children and youth are receiving wraparound like services. Both of these teams are also utilized to provide discharge planning for children who are in inpatient settings and juvenile detention centers.

The needs of all children and families are complex and ever changing. Over the years, many specialized systems including juvenile justice, child welfare, substance abuse, special education and mental health have evolved in an effort to respond to those needs. The services developed by these various systems are pre-designed to meet the needs of a typical child when, in fact, they are increasingly serving children and families with unique needs.

The Mental Health Division continues to encourage other child-serving agencies within DSHS to recognize children as “our state’s children” and will continue to discuss and find ways to eliminate the barriers to sharing information and data. Mental Health Division continues to encourage other state agencies such as schools and health departments to break down all barriers and to share data whenever possible to better serve the needs of children and their families.

For physical health care services, children have access through community providers who accept Medicaid and public assistance. Washington State also has a Basic Health Care Program to provide insurance coverage to families when there is none from the employer. Children in Basic Health have the same coverage as Medicaid eligible children. Additionally, there is several community clinics that provide service on a sliding scale basis for children of families with limited resources and two RSN have in their service area free mental health clinics.

Governor, Christine Gregoire, has embarked on a note-worthy effort to ensure every child in Washington State has healthcare coverage by 2010, which is consistent with and bolstered by several other initiatives and carve-outs within the state aimed at increasing access to quality medical and dental care.

Housing and residential needs persist across all ages and all ethnicities. While it is preferable to serve children in their homes within the structure of their natural supports,

sometimes children require the specialized care of inpatient services at the State Hospital's Child Study and Treatment Center (CSTC) or one of the other Children's Long-term Inpatient Program's (CLIP) residential facilities. Screening and referral protocols are in place for these services to improve access.

In addition to the services funded by MHD and other state agencies for the provision of system-wide services to children, the Mental Health Division funds mental health parent programs such as the Community Connector project and SAFE-WA which provides an essential link in the continuum of care that is often overlooked by formal systems. Parents have developed ways to survive the day to day stresses of caring for a special-needs child/youth. The Community Connectors and SAFE-WA allows for parents to help other parents who find themselves in a similar situation. These parents must have children, grandchildren or foster children with complex needs and be willing to network within their community.

Of special note is the forming network of dads providing support to each other. For many years, the MHD parent network had one or two dads. Staff met with dads alone at training to get their input on what they thought the dads might need to come together and support each other. Staff listened and tried to meet the need. A new organization has formed WADADs. To date, they have supported each other with the development of child specific IEPs and have mentored each other in the CLIP application process. The dads have established a website https://www.wadads.org where they post information, training events and have a chat room. In 2008, they are discussing more regional meetings with one or possibly two larger meetings.

- Many efforts have been made to improve the continuum of services to children across all social and health services.

Implementation continues to focus on workforce development. By supporting specialized training and certification for clinicians, significant workforce enhancement can be achieved without disruption to usual funding levels and service priorities.

Another strength of Washington's mental health system for children is a joint project initiated by MHD with the Office of the Superintendent of Public Instruction. The MHD and the Mental Health Transformation project are working together with the Office of the Superintendent of Schools (OSPI) to develop and conduct statewide train- the- trainer sessions focusing on public education and publicly funded community mental health service coordination. The report of this training effort is due in the Fall of 2009.

Individual service plans (WAC 388-865-0435) for children and youth require coordination with a child's IEP whenever it is possible and feasible. For children under three there is a requirement to that the plan must be integrated with the individual family service plan (IFSP) if it exists.

The individual service plan must look at all life domains and plan accordingly. Life domains are:

- Housing;
- Food;
- Income;
- Health and dental;
- Transportation;
- Work, school or other daily activities;
- Social life; and,
- Referral services as appropriate to treatment such as substance abuse.

The RSNs provide training to emergency room staff to help specifically identify mental health issues and to coordinate care with designated mental health professionals for community diversion for all ages. They employ children mental health specialists as part of their crisis teams and also as part of their training staff when working with ERs and EMT.s

Through the collaborative effort of MHD with the Division of Developmental Disabilities (DDD) yet another example of training provided to emergency and health providers is the Community Hospital MI/DD Training. Together, the Divisions are creating a training targeted to the community hospitals that serve persons with a dual diagnosis of mental illness and developmental disability on how to better understand, evaluate, triage, and treat this special population. Training is being provided to both Emergency Room staff as well as employees who would be providing inpatient treatment.

MHD is committed to providing training to the State's emergency and health providers. As the first responders, emergency and health providers being well trained and educated about persons with mental illness and available services will only help move our state toward Transformation.

A specific training for Children's Mental Health Specialists will again be held in September of 09.

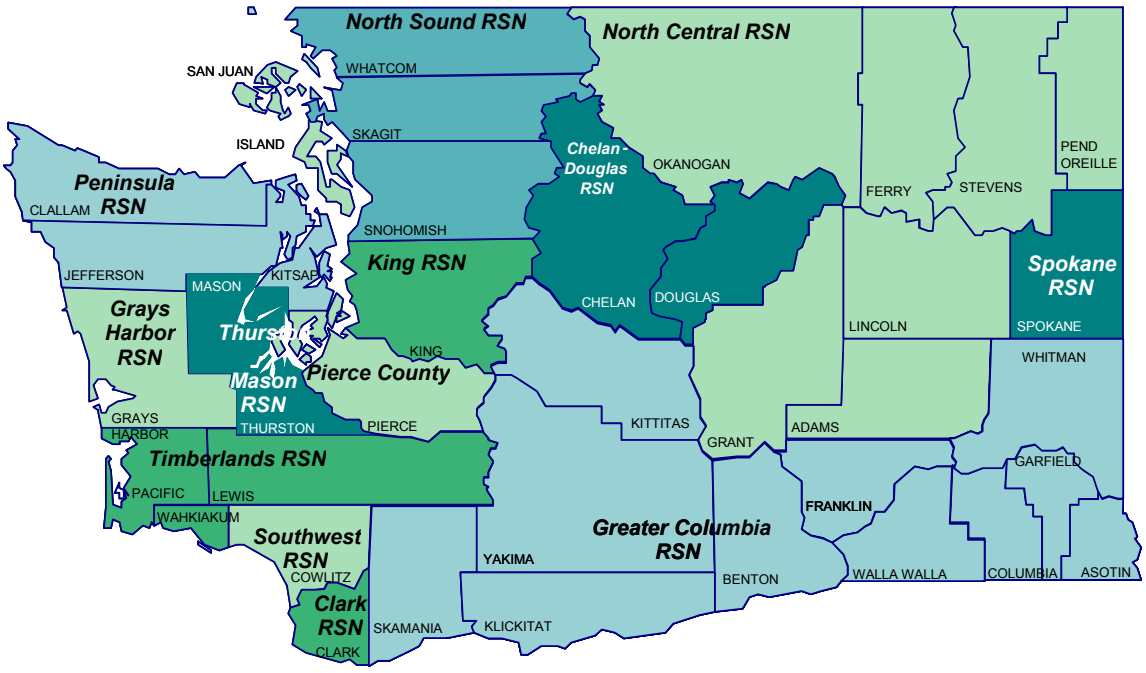
Washington

Child - Geographic Area Definition

Child - Establishes defined geographic area for the provision of the services of such system.

Services are provided to children through the same Regional Support Network (RSN) system as the adult. The map below reflects the current catchment areas for each RSN.

Washington State Regional Support Networks (RSNs)



Washington

Child - Outreach to Homeless

Child - Describe State's outreach to and services for individuals who are homeless

As this is mainly a combined plan, the description in the adult plan also addresses the issues for children, youth and their families.

However, MHD noted the very small numbers of homeless youth and their families being served by the system and made this a priority for federal block grant for 2009.

This brought to the attention the need for the RSNs to consider this population when planning for their funds. As such, some RSNs are targeting funds to children, youth and their families with the hope of increasing this number. Peninsula RSN for example, is funding a transitional supported living program for young adults age 18-24.

Another exciting issue is the addition of persons with mental illness being included in the Transitional Housing, Operating and Rent Program (THOR). This paper (below) along with the Common Ground contract should provide an increase in housing for families with mental illness.

"TRANSITIONAL HOUSING, OPERATING AND RENT (THOR) PROGRAM
RECENT CHANGES EXPAND ELIGIBLE HOUSEHOLDS TO INCLUDE INDIVIDUALS WITH MENTAL ILLNESS

Background

In 1999 the Legislature created a budget proviso of $5,000,000 to fund the Transitional Housing Operating and Rent (THOR) program as well as several other initiatives to help homeless families with children. The program operated within the Department of Community, Trade and Economic Development (CTED) and provided funding to non-profits, local government, and housing authorities to provide housing and services exclusively to homeless families with children. Since this time, funding has remained roughly consistent.

Until recently, approximately $2.2 million was awarded each year for rent assistance, operating subsidies for transitional housing facilities, case management, and administrative costs. *Local lead agencies covering 31 of 39 Washington State counties operate the THOR program. Click here for an interactive map of lead agency locations within Washington and a contact list is attached.

THOR funds are awarded to local lead agencies based on a modified version of the Department of Housing and Urban Development's (HUD) allocation formula for funding homeless shelters. In turn the lead agency can either directly provide or contract for the provision of THOR services. Contractors may include: a local government; a local housing authority; a regional support network established under chapter 71.24 RCW; a nonprofit community or neighborhood-based organization; a federally recognized Indian tribe in the state of Washington; or a regional or statewide nonprofit housing assistance organization.

Recent Changes

In 2008 the THOR program was put into statute within CTED through ESSB 5959 and the purpose of the program was expanded to assist homeless individuals as well as assist families in securing and retaining safe, decent and affordable housing. An additional $2.5 million has been provided (expansion funds) in the 2009 Supplemental budget.

THOR Services and Support

Grantee organizations may use the funds to provide from 91 days up to two years of:

- Rental assistance, including security deposits and moving expenses.
- Case management services designed to help the client move toward self-sufficiency.
- And exclusively for homeless families with children, operating expense subsidies for transitional housing facilities.

Homelessness Eligibility

All households must be homeless or at imminent risk of homelessness.

- Homeless means persons including families, who, on one particular day or night, do not have a decent and safe shelter or sufficient funds to purchase a place to stay, or are living in places not intended for human habitation.

- Imminent risk of homelessness means persons including families who can provide proof of imminent housing loss or are currently residing in homeless shelters, temporarily living with family or friends, about to be released from prison or jail, or leaving a mental health or chemical dependency treatment facility, and have no identified housing option.

Eligible households include:

- Families with children.
- Families with children who are receiving services under chapter 13.34 RCW.
- Individuals or families without children (eligible only with expansion funds).
- Individuals or families who have a household with an adult member who has a mental health or chemical dependency disorder (individuals and families without children are eligible only with expansion funds).
- Individuals or families who have a household with an adult member who is an offender released from jail or prison within the past 18 months (individuals and families without children are eligible only with expansion funds).

Income Eligibility

- Families with children must not have an income that exceeds 50 percent of area median income as published by HUD.
- Individuals or families without children must not have an income that exceeds 30 percent of the area median income as published annually by HUD."

The MHD's KidTeam believes that there are barriers to serving homeless youth and will be contracting with a Provider to develop a plan. The provider has a children's expert on homelessness and in the past operated a homeless youth outreach program. Ideally, the provider will coordinate with Youth 'N Action to obtain actual feedback from the youth who have turned their lives around. The Contractor will gather information from other providers across the state, develop a report for MHD on the barriers of serving this population, and provide some outreach services to youth. This plan/project will be coordinated with the work of STI around issues and high risk behaviors faced by youth.

Washington

Child - Rural Area Services

Child - Describes how community-based services will be provided to individuals in rural areas

As this is mainly a combined plan, the description in the adult plan also addresses the issues for children, youth and their families.

As stated, þÿ M H D s c o n t r a c t s w i t h t h e R S N s h a s accessing services and the MHD has supported training activities on the specialized needs of consumers in these less populated areas, and participating in the rural mental health conferences.

The use of telemedicine sites for the provision of services has increased access to child psychiatrists and other child mental health specialists for the rural areas. Child psychiatrists in rural eastern Washington are few and far between, this technology provides access to services at the University of þÿ W a s h i n g t o n , C h i l d r e n s H o s p i t a l , a n d o t h

In its contract with SAFE-WA, the statewide parent network, the MHD has required that they provide training for parents and parent/professional training twice a year in rural eastern Washington. The Parent Coordinator for SAFE-WA has been working in rural southeastern Washington to develop a parent support organization. She has been more successful than past tries in þÿ c o n v i n c i n g t h e p r o v i d e r s t h a t t h i s p e e and the parents.

Both the Grays Harbor and Southwest RSN WrapAround Pilot projects are in rural parts of Washington. The Thurston Mason EBP pilot site is also in the most rural part of Thurston County.

Washington

Child - Resources for Providers

Child - Describes financial resources, staffing and training for mental health services providers necessary for the plan;

Please see the adult plan for financial and staffing resources.
Children's mental health specialists are required to oversee treatment of children. Children's mental health specialists are mental health professionals with a minimum of 100 hours actual hours of special training in child development and the treatment of children and youth with SED and their families. Additionally they must have one-year of full-time experience in treatment of children with SED under the supervision of a child mental health specialist.

In the WrapAround pilots, all service providers will recieve training.

Washington

Child - Emergency Service Provider Training

Child - Provides for training of providers of emergency health services regarding mental health;

Please see the adult plan.
It is important to note in this section that through both SAFE-WA and WADADs a relationship has been developed between several law enforcement agencies and the parent organziations. Parents are providing "in-service" training to police officers and other first responders on their children. At the 2-day Dad's training in August 3 dads brought with them members of their local police force who just wanted to "learn" from the fathers.
SAFE-WA also has a network member who works closely with their local juvenile court and police.

King County RSN has a crisis team of children's specialist, parents and youth trained to assit in the field.

Washington

Child - Grant Expenditure Manner

Child - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved

please see the adult section and other sections of the plan about expenditures. In our system, we do not seperate out funding by age group but on a population distribution formula. However, we estimate if the RSNs fully implement their plans that $1,920,268 will be spent on children and youth related activities. MHD historically spends between fifteen and twenty percent of their block grant funds on parent and youth activities.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	36,005	35,673	35,241	35,241	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: #1: Increase Access to Services for Children and Youth with SED

Target: Number of children and youth served through the public mental health system: 35,241

Population: Children and Youth with SED

Criterion: 2:Mental Health System Data Epidemiology
3:Children"s Services

Indicator: RSNs and MHD will work to increase the number of children and youth served through the public mental health system, with focus given to special populations.

Measure: Number of children/youth (ages 0-17) served in community outpatient setting. (No Numerator of Denominator required.)

Sources of Information: MHD-Consumer Information System (CIS).

Special Issues: Beginning in CY2008, Pierce COunty discontinued to operate as the Regional Support Network (RSN). Instead, the region was converted to a fee for service program for Medicaid mental health services and direct provider contracts were established for the allocation of state funds for crisis, residential and evaluation and treatment services. Pierce service encounter data is therefore submitted to MHD via different transactions and channels. Pierce region data is not ready for reporting at the time this application is being prepared.

FY2008 projected number: For the service encounter data missing between January and June of 2008 for Pierce region, we used the actual count of unique consumers served by Pierce RSN in the same time period in 2007.

Significance: This is a required National Outcome Measure (NOM). No Numerator or Denominator required. Goal supports New Freedom Commission (NFC) goal #4. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #4.

Action Plan: Support the growth of a culturally competent workforce by training those who serve children and youth within the following special populations: American Indians, Alaska Natives and their communities, Ethic Minorities, Sexual Minorities, Hearing Impaired, and Developmentally Disabled. Support activities geared toward helping children and youth obtain eligibility for social services including mental health, physical health, and dental care. Support efforts to create Electronic Medical Records. Continue to collaborate with other agencies to better support consumers/families served by multiple agencies. Encourage early prevention and intervention activities through collaboration with schools, foster care system, and juvenile justice.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	5.89	5.64	5.90	5.90	N/A	N/A
Numerator	46	55	--	--	--	--
Denominator	781	975	--	--	--	--

Table Descriptors:

Goal: #2: Decrease percentage of children and youth who are readmitted to an inpatient setting within 30 days of discharge.

Target: The percentage of children and youth readmitted to any inpatient setting within 30 days of discharge – 5.9%

Population: Children with Significant Emotional Disturbance (SED)

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Regional Support Networks (RSNs) will minimize the percentage of children and youth who were discharged from a state hospital, community hospital, or freestanding evaluation and treatment facility and then readmitted to any of the inpatient settings within 30 days.

Measure: Numerator: Number of children and youth (ages 0-17) readmitted to any inpatient setting within 30 days of discharge in the fiscal year Denominator: Number of total children and youth discharges from any inpatient setting in the Fiscal year.

Sources of Information: MHD-Consumer Information System (CIS).

Special Issues: Beginning in CY2008, Pierce COunty discontinued to operate as the Regional Support Network (RSN). Instead, the region was converted to a fee for service program for Medicaid mental health services and direct provider contracts were established for the allocation of state funds for crisis, residential and evaluation and treatment services. Pierce service encounter data is therefore submitted to MHD via different transactions and channels. Pierce region data is not ready for reporting at the time this application is being prepared.

FY2008 projected percentage: Did not include Pierce region 2008 data.

Significance: This is a required National Outcome Measure (NOM). No Numerator or Denominator required. Goal supports New Freedom Commission (NFC) goal #4. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #4Decreasing returns to hospitals demonstrates increased community tenure which evidences recovery and adequate community supports.

Action Plan: Establish appropriate use and capacity of state psychiatric hospitals and promote services delivered in community settings through support and development of hospital diversion residential resources in the community. Continue to require through contract that persons discharged from the state hospitals are seen within __ days. Continue to expect RSNs to maintain percentage of outpatient children and youth who are NOT hospitalized as a rate >95%. Encourage development of community resources for kids as alternatives to hospitalization. Evaluate function of Children's Long-term Inpatient Program (CLIP) and support coordination efforts.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	20.82	15.40	15.40	N/A	N/A
Numerator	N/A	203	--	--	--	--
Denominator	N/A	975	--	--	--	--

Table Descriptors:

Goal: #3: Decrease percentage of children and youth who are readmitted to an inpatient setting within 180 days of discharge.

Target: The percentage of children and youth readmitted to any inpatient setting within 180 days of discharge –15.4%

Population: Children with Significant Emotional Disturbance (SED)

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Regional Support Networks (RSNs) will minimize the percentage of children and youth who were discharged from a state hospital, community hospital, or freestanding evaluation and treatment facility and who were then readmitted to any of the inpatient settings within 180 days.

Measure: Numerator: Number of children and youth (age 0-17) readmitted to any inpatient setting within 180 days of discharge Denominator: Number of total children and youth discharges from any inpatient setting.

Sources of Information: MHD-Consumer Information System (CIS).

Special Issues: In FY2006 no target was set as it was a new measure. Previous plan was to maintain a readmission rate
Beginning in CY2008, Pierce COunty discontinued to operate as the Regional Support Network (RSN). Instead, the region was converted to a fee for service program for Medicaid mental health services and direct provider contracts were established for the allocation of state funds for crisis, residential and evaluation and treatment services. Pierce service encounter data is therefore submitted to MHD via different transactions and channels. Pierce region data is not ready for reporting at the time this application is being prepared.

FY2008 projected percentage: Did not include Pierce region 2008 data.

Significance: This is a required National Outcome Measure (NOM). No Numerator or Denominator required. Goal supports New Freedom Commission (NFC) goal #4. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #4. Decreasing readmission to hospitals demonstrates increased ability to maintain community tenure which further evidences the presence of adequate community supports and improved resiliency.

Action Plan: Establish appropriate use and capacity of state psychiatric hospitals and promote services

delivered in community settings through support and development of hospital diversion residential resources in the community. Continue to require through contract that persons discharged from the state hospitals are seen within 7 days. Continue to expect RSNs to maintain percentage of outpatient children and youth who are NOT hospitalized as a rate >95%. Encourage development of community resources for kids as alternatives to hospitalization. Evaluate function of Children's Long-term Inpatient Program (CLIP) and support coordination efforts.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Evidence Based - Children with SED Receiving Therapeutic Foster Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	520	520	520	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: #5: Increase the number of EBPs received by children and youth

Target: The number of children and youth receiving Therapuetic Foster Care services is 520:

Population: Children with Significant Emotional Disturbance (SED)

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Regional Support Networks (RSNs) and MHD will work to increase the number of children and youth receiving EBP treatment throughout the state.

Measure: Number of children and youth mental health consumers throughout the state who received therapuetic foster care services (No numerator or Denominator required.)

Sources of Information: A Provider Survey conducted by Washington Institute of Mental Health research and Training (WIMHRT).

Special Issues: Counts of the number of clients who receive therapuetic foster care services are provided by provider agency self-report on a survey. There is some question about thether the counts of clients who receive each EBP are overcounts. Also there is no way to unduplicate client counts across provider agencies.

FY2008 data is not available at the time this application is being prepared.

Significance: This is a required National Outcome Measure (NOM). No Numerator or Denominator required. Goal supports New Freedom Commission (NFC) goal #4. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #4.

Action Plan: Support training across spectrum of administrators, providers, and consumer/family members related to the research, development, or movement of best practices to EBPs as well as implementation of EBPs that are culturally competent. Oversee the implementation of six (6) 2006 legislatively funded PACT Teams. Disseminate EBP Resource Guides. Support Mental Health Specialist.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Evidence Based - Children with SED Receiving Multi-Systemic Therapy (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	1,314	1,314	1,314	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To increase the number of children/youth who receive multi-systemic therapy.

Target: The number of children/youth who receive multi-systemic therapy is: 1,314

Population: Children/Youth with serious emotional disturbance.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Number of children and youth who receive multi-systemic therapy.

Measure: Number of children and youth who receive multi-systemic therapy.

Sources of Information: Provider survey conducted by Washington Institute for Mental Health Research and Training (WIMHRT).

Special Issues: Counts of the number of clients who receive multi-systemic therapy are provided by provider agency self-report on a survey. There is some question about whether the counts of clients who receive each of the EBPs are overcounts. Also there is no way to unduplicate client counts across provider agencies.

FY2008 data is not available at the time this application is being prepared.

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Evidence Based - Children with SED Receiving Family Functional Therapy (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	1,335	1,335	1,335	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To increase the number of children and youth who receive family functional therapy

Target: The number of children and youth who receive family functional therapy is:1,335

Population: Children with serious emotional disturbance

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Number of children and youth who receive family functional therapy

Measure: Number of children and youth who receive family functional therapy

Sources of Information: Provider survey conducted by Washington Institute for Mental Health Research and Training (WIMHRT)

Special Issues: Counts of the number of clients who receive Family Functional Therapy are provided by provider agency self-report on a survey. There is some question about whether the counts of clients who receive each of the EBPs are overcounts. Also there is no way to unduplicate client counts across provider agencies.

FY2008 data is not available at the time this application is being prepared.

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	65.30	64	64	N/A	N/A
Numerator	N/A	574	--	--	--	--
Denominator	N/A	879	--	--	--	--

Table Descriptors:

Goal: #6: Improve client perception of care- children and youth.

Target: The percentage of children and youth who report achieving positive outcomes on the MHSIP Survey:64%

Population: Children with Significant Emotional Disturbance (SED)

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Regional Support Networks (RSNs) will work to improve children and youth client perception of care as evidenced by the number of adults surveyed who agree with the items on the MHSIP regarding their perception of positive outcomes.

Measure: Numerator: Number of children and youth (age 0-17), parents, and caregivers of children under 13 years of age who agreed or strongly agreed with the MHSIP Outcomes Scale. Denominator: Number of children and youth (age 0-17), parents, and caregivers of children under 13 years of age who took the survey.

Sources of Information: This is new data being acquired through the MHSIP survey conducted by Washington Institute for Mental Health research and Training (WIMHRT).

Special Issues: WA has only conducted the Child/Youth MHSIP every other year, with the off years being used to conduct Adult surveys. Beginning in 2007, however, the MHSIP will be conducted on a yearly basis for both populations, per SAMHSA requirements re: yearly reporting on this NOM.

The difference in the percentage reported between FY2007 and FY2008 is within the margin of error with a 95% confidence interval.

Significance: This is a required National Outcome Measure (NOM). No Numerator or Denominator required. Goal supports New Freedom Commission (NFC) goal #4. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #4

Action Plan: Continue to support training across spectrum of administrators, providers, and consumer/family members related to articulated child/youth/family voice. In particular, Recovery, Consumer Driven service system, and culturally competent care initiatives will be emphasized. OMBUDS training will also be supported. Individual choice, satisfaction, and safety will continue to be encouraged for children/youth/families. Parent support and empowerment will continue to be supported, including having a parent serve on MHD Management Team.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Child - Return to/Stay in School (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	25	24.50	24.50	N/A	N/A
Numerator	N/A	220	--	--	--	--
Denominator	N/A	880	--	--	--	--

Table Descriptors:

Goal: #7: Decrease the number of children/youth suspended or expelled from school

Target: The percentage of children/youth suspended or expelled from school is 24.5%:

Population: Children with significant emotional disdurbance (SED)

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Number of children and youth (0-17) suspended or expelled from school

Measure: Numerator: Number of children/youth were expelled or suspended from school during the last 12 months. Denominator: Number of respondents (caregiver/youth) to the YSS-F survey.

Sources of Information: YSS-F survey conducted by Washington Institute for Mental Health Research and Training (WIMHRT)

Special Issues: WA has measured other activities such as school performance in the past. Prior to 2007, the YSS-F survey and adult MHSIP survey were conducted on alternating years, but beginning in FY2007, both surveys are conducted every year as per SAMHSA requirements re: yearly NOM reporting related to this indicator.

Significance: This is a National Outcome Measure (NOM). Goal suports New Freedom Commission (NFC) goal #4. Goal supports Mental Health Planning and Advisory (MHPAC Goal #4.

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Child - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	47.50	51	51	N/A	N/A
Numerator	N/A	19	--	--	--	--
Denominator	N/A	40	--	--	--	--

Table Descriptors:

Goal: #8: Decrease the percentage of children and youth consumers who have had involvement with the juvenile justice system

Target: The percentage of youth consumers who were arrested in T1 and not rearrested in T2 is: 51%:

Population: Children with Significant Emotional Disturbance (SED)

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: RSNs and MHD will work to decrease the number of youth consumers who were involved with the criminal justice system.

Measure: Prior to 2007: Numerator: Number of children/youth who were arrested convicted or adjudicated in the fiscal year. Denominator: Number of total children/youth (0-17) served by the mental health division in the fiscal year.
FY2007 and forward: Numberator: From the MHSIP survey, number of chilren/youth who reported being arrested in the fiscal year. Denominator: Number of children/youth who responded to MHSIP survey and who reported being arrested in the previous year.

Sources of Information: Prior to 2007:Merging the MHD data with state arrest and conviction data.
FY2007 and forward: MHSIP survey conducted by Washington Institute for Mental Health Research and Training (WIMHRT).

Special Issues: Prior to FY2007: Obtaining timely data from Washington State Patrol and Office for the Administrator of the Courts was difficult due to system/reporting limitations. Therefore, data for this indicator is now obtained from the YSS-F survey. Administrative data shows much higher rates than survey self report.

Significance: This is a National Outcome Measure (NOM). Goal supports New Freedom Commission (NFC) goal #4. Goal supports Mental Health Planning and Advisory Council (MHPAC) Goal #4.

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Child - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	98.35	98.30	98.30	N/A	N/A
Numerator	N/A	23,160	--	--	--	--
Denominator	N/A	23,549	--	--	--	--

Table Descriptors:

Goal: #10: Increase family stability as evidencec by children and youth maintaining housing

Target: The percentage of children and youth who received outpatient mental health services who did not become homeless in the fiscal year: 98.3%

Population: Children and youth with serious mental disburbance

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Percentage of children and youth who did not become homeless in the fiscal year

Measure: Numerator: Number of chilren and youth (0-17) with 2 ore more living situations recorded who did not become homeless in a fiscal year.
Denominator: Number of total children and youth (0-17) served in community outpatient services in the fiscal year

Sources of Information: MHD-Client information system (CIS)

Special Issues: Stable housing continues to be a real and serious challenge for WA; however MHD remains committed to encouraging growth of appropriate residential resources and supports for children, youth, and familes through the RSNs.

Beginning in CY2008, Pierce County discontinued to operate as the Regional Support Network (RSN). Instead, the region was converted to a fee for service program for Medicaid mental health services and direct provider contracts were established for the allocation of state funds for crisis, residential and evaluation and treatment services. Pierce service encounter data is therefore submitted to MHD via different transactions and channels. Pierce region data is not ready for reporting at the time this application is being prepared.

FY2008 projected percentage: Did not include Pierce region 2008 data.

Significance: Goal supports New Freedom Commission (NFC) goal #3. Goal supports Mental Health Planning and Advisory Council (MHPAC) Goal #3

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Child - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	85.92	85.80	85.80	N/A	N/A
Numerator	N/A	763	--	--	--	--
Denominator	N/A	888	--	--	--	--

Table Descriptors:

Goal: #8: Increase the sense of social connectedness experienced by children and youth

Target: The percentage of children and youth reporting positively to social connectedness scale on the YSS-F survey is: 85.8%

Population: Children with Significant Emotional Disturbance (SED)

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: RSNs will work to assist children and youth consumers in increasing their social and natural supports.

Measure: Numerator: Number of children and youth responded that they agree or strongly agree to the 4 items that make up the social connectedness scale on the YSS-F survey.
Denominator: Number of total children and outh who responded to the YSS-F survey

Sources of Information: YSS-F survey conducted by Washington Institute for Mental Health Research and Training (WIMHRT)

Special Issues:

Significance: This is a National Outcome Measure (NOM). Goal supports New Freedom Commission (NFC) goal #3. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #3. Having meaningful relationships is a necessary part of increasing likelihood of resiliency.

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Child - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	65.42	66	66	N/A	N/A
Numerator	N/A	575	--	--	--	--
Denominator	N/A	879	--	--	--	--

Table Descriptors:

Goal: #9: Improve level of functioning for children and youth

Target: The percentage of children and youth agree or strongly agree to the functioning question on the YSS-F survey:66%

Population: Children with significant emotional disturbance (SED)

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services
4:Targeted Services to Rural and Homeless Populations

Indicator: RSNs will work to increase the number of children and youth who report improved level of functioning over a fiscal year

Measure: Numerator: Number of children and youth respond agree or strongly agree to the functioning question on the YSS-F survey.
Denominator: Number of total children and youth who responded to YSS-F survey in the fiscal year

Sources of Information: YSS-F survey conducted by the Washington Institute for Mental Health Research and Training (WIMHRT)

Special Issues:

Significance: This is a National Oucome Measure (NOM). Goal supports New Freedom Commission (NFC) goal #3, #4, #5. Goal supports Mental Health Planning and Advisory (MHPAC) Goal #3, #4, #5.

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: 3.07 Increase in Employment or Return to School - Children and Youth

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	24.20	N/A	N/A	N/A	N/A
Numerator	N/A	220	--	--	--	--
Denominator	N/A	880	--	--	--	--

Table Descriptors:

Goal: #7: Increase the number of children and youth who are engaged in employment related activities or attending school.

Target: This indicator will be reported in NOMs beginning FY2008.

Population: Children with Significant Emotional Disturbance (SED)

Criterion: 3:Children"s Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: 3.08 Decrease Criminal Justice Involvement - Children and Youth

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	13.30	7.40	N/A	N/A	N/A	N/A
Numerator	4,988	67	--	--	--	--
Denominator	37,413	882	--	--	--	--

Table Descriptors:

Goal: #8: Decrease the percentage of children and youth consumers who have had involvement with the juvenile justice system

Target: This indicator will be reported in NOMs beginning FY2008.

Population: Children with Significant Emotional Disturbance (SED)

Criterion: 3:Children"s Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: 3.09 Increase Social Supports - Children and Youth

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	85.90	N/A	N/A	N/A	N/A
Numerator	N/A	763	--	--	--	--
Denominator	N/A	888	--	--	--	--

Table Descriptors:

Goal: #9: Increase the number of social and natural supports reported by children and youth consumers.

Target: This indicator will be reported in NOMs beginning FY2008.

Population: Children with Significant Emotional Disturbance (SED)

Criterion: 3:Children"s Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: 3.10 Increase Family Stabilization/Living Conditions - Children and Youth

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	98.30	98.30	N/A	N/A	N/A	N/A
Numerator	24,885	23,160	--	--	--	--
Denominator	25,354	23,549	--	--	--	--

Table Descriptors:

Goal: #10: Increase family stabilization as evidenced by children and youth maintaining housing.

Target: This indicator will be reported in NOMs beginning FY2008.

Population: Children with Signifcant Emotional Disturbance (SED)

Criterion: 3:Children"s Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: 3.11 Improved Level of Functioning - Children and Youth

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	73	N/A	N/A	N/A	N/A
Numerator	N/A	638	--	--	--	--
Denominator	N/A	874	--	--	--	--

Table Descriptors:

Goal: #11: Improve level of functioning for Children and Youth as evidenced by increased involvement in meaningful activities

Target: This indicator will be reported in NOMs beginning FY2008.

Population: Children with Significant Emotional Disturbance (SED)

Criterion: 3:Children"s Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑☐

Name of Performance Indicator: 5.1 Develop/Enhance skilled workforce

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: #1: To improve First Responders' ability to identify and interact with mental health consumers.

Target:

Population:

Criterion: 5:Management Systems

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: 5.1 Research and Quality Improvement

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: #1: Improve quality of services supported with MHBG funds.

Target:

Population:

Criterion: 5:Management Systems

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: 5.2 Workforce Development

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	5	5	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: #2: Develop and enhance highly skilled workforce.

Target: Support 5 members of MHPAC in attending national MHBG Conference.

Population: Adults, Children and Youth with Serious Emotional Disturbance.

Criterion: 5:Management Systems

Indicator: MHD will work to improve the skills and efficacy of Division staff as well as members of MHPAC through select trainings and conferences.

Measure: Number of MHPAC members who attend national MHBG Conference.

Sources of Information: MHD self report.

Special Issues: There are limited resources available for workforce improvement.

Significance: MHD is committed to improving the skills of MHD staff and members of MHPAC in an effort to ensure the public mental health system provides excellent mental health services that align with the principles of Recovery and Resiliency and that move the system toward Transformation.

Action Plan: Continue to support MHPAC activities including opportunities to attend national conferences. Continue to support MHD staff training opportunities as well as Emergency/Disaster Preparedness. Focus will also be on trainings in Recovery and Resiliency, EBPs, cultural competency, housing, employment and safety.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑☐

Name of Performance Indicator: 5.3 Recovery Oriented System of Care

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: #3: Facilitate growth of Recovery-Oriented system of care.

Target:

Population:

Criterion: 5:Management Systems

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

Washington

Planning Council Letter for the Plan

Upload Planning Council Letter for the Plan

Mental Health Planning & Advisory Council

Vision
Plan, Advocate, Evaluate
Mission
To advocate for a system that supports persons impacted by mental disorders on their journeys to achieve the highest quality of life possible by promoting evidence-based, cost-effective, individualized mental health services.

Cathii Nash, Chair
3908 East 17th
Spokane, WA 99223
(509) 536-4136

August 15, 2008

Barbara Orlando
Grants Management Specialist
Division of Grants Management, OPS, SAMHSA
1 Choke Cherry Road, Room 7-1091
Rockville, Maryland 20857

Dear Ms. Orlando,

The Washington State Mental Health Planning and Advisory Council ("the Council") supports and endorses the Washington State Mental Health Division's (MHD) State Plan and application for the Federal Block Grant for the year 2008/2009. The Council was guided by SAMHSA criteria and Washington State's commitment to transform the mental health system by focusing services on recovery and resiliency. The Council reviewed this letter on August 12, 2008, and voted unanimously to accept it. There were no descending votes or abstentions.

The Council met throughout the months of May and June, in person, by teleconference and by email to review the Federal Block Grant and we're extremely pleased with both the Regional Support Network's (RSN's) proposals and the MHD support which made them possible. One-hundred and forty-six programs were individually reviewed for funding, based on SAMHSA criteria and our goals. The attached twelve-page letter was written by the Council to the MHD on June 6, 2008. The MHD relayed these comments directly to the RSN's, giving them an opportunity to change and amend their proposals, which most did.

It must be noted here, that of the four largest concerns expressed by the Council, listed on page 2 of our attached letter, one item was removed from the contract ($5000 for loss of business due to training) and one was settled by contact with SAMHSA (tele-health equipment). Of the two remaining, the ICOS program in Spokane was denied their funding until their DASA licensing issues were cleared up (or a different contractor found) and King County was given one more year to change its funding methods for crisis services.

In 1998, the Washington State Legislature funded a joint pilot project with the Department of Corrections (DOC), the Department of Social and Health Services (DSHS), and the King County RSN. The pilot was referred to as the Mentally Ill Offender Community Transition Program (MIO-CTP). In 2003 the follow-up report to the Legislature showed declines in recidivism and increases in successful transitions into the community. At that time, the Legislature voted to continue the collaborative funding, adding to it the Federal Block Grant funds. For the fifth year, the Council has not been allowed to follow its federal mandate to review and recommend this expenditure. Based on the facts that it is not a State-wide program and we were not allowed to comment, the Council continues to vote to NOT recommend this specific part of the funding for 2008/2009. We look forward to working with the MHD and the Legislature this coming session to release these monies back to the Council and the MHD and finding funding outside this arena.

It was decided by the Council and the MHD that next year's process for the Federal Block Grant will begin in January to allow more discussion and education of the RSNs and their Advisory Boards. "Lack of time" to plan ahead was the most commonly heard comment regarding the FBG and the Council believes it can be of

assistance in this regard. This will also allow more contact between the Subcommittees and the RSNs to address their concerns (listed on page 3). With Richard Kellogg's support and encouragement, we look forward to even more consumer voice and direction in the use of the Federal Block Grant in the years to come.

The Council's special thanks go out to Governor Gregiore and all the people at the Washington State Mental Health Division, NAMPHAC, and SAMHSA for their support and encouragement that make these grants possible.

Sincerely,

Cathii Nash, Chair
Washington State MHPAC

Rick Crozier, Vice-Chair
Washington State MHPAC

CC: Richard Kellogg, MHD Director
Doug Porter, HRSA Director
Robin Arnold-Williams, Secretary, DSHS

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Cathii Nash, Chair
3908 East 17th
Spokane, WA 99223
(509) 536-4136

Richard Kellogg, Director
Mental Health Division
PO Box 45320
Olympia, WA 98504-5320

Judy Gosney,
Federal Block Grant Writer
PO Box 45320
Olympia, WA 98504-5320

Dear Richard Kellogg and Judy Gosney,

The process for reviewing the applications for the RSN proposals for the 2009 / 2010 Federal Block Grant has been a very interesting. The Program /Planning Subcommittee developed a decision matrix specifically for these proposals and the Council spent a great deal of time reviewing the proposals in detail. The matrix was successful in capturing the Council's attention and focused on the goals and criteria as set forth by both SAMSHA and the MHD. The Council was divided into 7 workgroups that reviewed each proposal and averaged each RSN's scores among themselves. Rick Crozier and I both recused ourselves from any vote and members of the Council that had strong relationships with any particular RSN (good or bad) also recused themselves from that RSN's vote.

On pages 4 through 11, you will find a program by program breakdown of each RSN's proposals, with comments written in red and italicized.

The good news is that more than a couple pockets of innovative miracles were found. I would like to note them here: North Central is funding a mental health professional to be at a health clinic two days per week and hopes to see 150 clients. North Sound will be spending part of its FBG with non-Medicaid children in school, which will allow the schools to directly contract with the MHP on a fee-for-service basis. Peninsula RSN will be funding an Ombuds for non-Medicaid persons. Pierce's HEROS program will be 'tweaking' the Gatekeeper program to include home visits by therapists and peer counselors. Flex funds for medication and housing assistance were proposed by Gray's Harbor, Peninsula, Timberlands, and Thurston-Mason. North Central will be writing MOU's with local law enforcement to reduce JRA convictions. Clark County will be spending nearly 50% of its FBG on a consumer-run program. Thurston-Mason will be funding a free mental health clinic. All great programs – exhibiting out-of-the-box thinking! We wish them well!

One over-riding concern that many members of the Council struggled with in these proposals was that all of the RSNs chose to say that a specific program fulfilled a particular Criteria, but did not mention which subset was to be fulfilled. Of the 165 programs reviewed, twenty-one mentioned the subset and 143 did not. Were we to assume that these programs would fulfill all -or none -of the subset criteria? Over all, most of the RSN's agreed to translate their outcomes by using the NOMs as required by the State and SAMHSA. We look forward to seeing their reports in the coming year.

When you read pages 4 - 11 you will see three comments fairly often. The question of why the FBG continues to fund peer counselors when it is an established reimbursable Medicaid expense was a complete surprise to us, as we had mentioned this in last year's letter to the Division. We hope that these proposals can be changed to specify peer services to non-Medicaid consumers so that we are not in violation of SAMSHA rules regarding the FBG/Medicaid funding. The second comment that you will see fairly often is the use of parent

partners and consumer advocates. Are they seeing only non-Medicaid consumers or is the FBG paying for services from a non-certified peer? What can we do – as a Council and at the Division, to encourage these wonderful people into getting their peer certification? The third most common comment you will find is one that is often brought up at the Council and that is the question of Staff trainings. Training is always a good thing; however, it would be helpful to the Council to ask for consumer outcomes at these trainings. How many consumers will be touched by these trainings? Are the front-line staff being trained or is it administrative and RSN staff? What, if any, timelines are available for when these trainings will be put into action with consumer outcomes available?

Also of concern to the Council were the number of programs that listed administrative pay and/ or benefits for running the program. Of particular note were the Pierce programs, such as Pebbles in the Pond, A Common Voice and Pierce College. Can these proposals be re-written so that it does not seem like such a blatant violation of the second mandate of 'thou shall not fund' from SAMHSA?

Only a few programs drew the negative attention of the Council and of the Program/Planning Subcommittee and for those **we ask your support in holding their funding until a new proposal(s) can be sent to the Division and then to the Council for review.** They are as follows:

- King County is proposing to spend $1.6 million of its $1.7 FBG on crisis services (Emergency Telephone, Children's Crisis Outreach and Geriatric Crisis). Crisis services are guaranteed and mandated by the State to be in place for all people – no matter the age, race, or Medicaid status - and the State funds those services. Other RSN's find ways (other than FBG) to fund these same services. We suggest that King County RSN re-work their proposals.
- North Central is proposing to fund equipment for a $32,000 telehealth system. The rules from SAMHSA are very clear that equipment costs shall not exceed $5000. Judy, you had mentioned that somebody at SAMHSA said that this was "OK", but it would be helpful to have a letter on file to that effect before we go to Peer Review in September.
- Greater Lakes in Pierce County has requested $30,600 to send 4 of its staff to DBT training. $5000 of that ($1/6^{th}$) is stated to be for "loss of revenue" while the therapists are in training. Not only is this a poor business practice, we find it hard to believe that any therapist would leave without his/ her client base being covered in their absence.
- The ICOS program in Spokane County has requested $181,577. We've attached two letters from the DASA certification team (pages 12-15) explaining why Spokane Mental Health was denied continued exemption to their certification to serve co-occurring disease. We feel that they may not meet the standard of a 'qualified vendor' for this type of program. Plus, if we did agree to this funding it would be a slap in the face to DASA and hold meaningless their contributions to the COD programs around the Nation. There are at least two other contractors in Spokane that could fill the shoes of REM / ICOS and they would probably produce better outcomes than servicing 33 people in the last quarter of 2007 (at a cost of $45,000 per quarter).

All RSN's, plus Pierce, did a wonderful job of attaching their Advisory Board's letter and we are pleased with that. Spokane's additional two letters were also insightful. Ninety percent of the total FBG for Spokane is controlled by one provider, which is not a sign of a healthy (or a competitive) mental health system. Innovation often comes from competition. We also worry about any provider becoming wholly dependant on financing any program through the FBG. As you know, the FBG can be eliminated with a single stroke of a Congressional pen and we are concerned for those consumers that can be hurt in the process of political wrangling. Although we have no desire to decide where Spokane will utilize its FBG, we certainly encourage them to listen to their Advisory Board (AB) and begin planning ahead to next year's Block Plan much earlier in the year. (I know of one RSN that posts notice for Block Grant Proposals as early as February.) If Spokane would like assistance with this, there are at four MHPAC Council members and 5 Subcommittee members that live in the Spokane RSN. I'm sure we could arrange to meet with the AB and RSN staff for training and discussion, if desired. And, of course, we would hope the Spokane RSN and its AB would take advantage of its

Administrative meetings and our joint RSN/ MHPAC meetings scheduled through the year to gain new information about the FBG, our goals and the State's and SAMHSA's criteria.

The Council's Subcommittees should also be commended for the efforts and time they took to provide comment on the FBG proposals, as well. The following are a synopsis of their reports (full copies of their letters and data sheets can be supplied to the Division by written request to the Council):

- OATS (Older Adult Treatment) reviewed the proposals and were genuinely pleased that funding for Older Adults had increased from 6 to 11% this year. Eight RSN's submitted seventeen proposals for Older Adults programs. Five RSN's mentioned nothing in regard to this population's needs. Although this percentage does not reflect the actual census population within the State, it is a lot closer than it's ever been. We celebrate it!
- ACS (Adult Consumer Subcommittee) was particularly dismayed that so few consumer run / operated programs were being supported. They also felt the RSN proposals lacked consumer input, diversity and cross-cultural involvement, as well as programs of crisis prevention and wellness.
- EMAC (Ethnic Minority Advisory Subcommittee) was disheartened to report that, other than Tribes, no cultural or ethnic minority populations were specifically called-out in any of the proposals. EBP's are still lacking in regards to ethnic minorities and outcomes are skewed in the direction of non-minority cultures and ethnic groups. "There were limited numbers of proposals that met quality standards for the FBG with cultural sensitivity."
- Children's (CTSS) reported was based on their decision matrix from 2006. They found 28% of the FBG received by RSN's are being spent by seven RSN's on children's programs (including crisis) and the remaining six spent no FBG on children. They also had more questions than answers for the Council and the Division to answer.
- Legislative/Administrative reported a lack of consumer input into the planning of many of the proposals and a large disparity of consumer run / operated programs in this State requesting FBG funds. They also noted the apparent lack of cross-agency work within the RSN's, as well as the need for more defined cross-cultural specifications within the proposals.
- SMS (Sexual Minority Subcommittee) reported no RSN reported any program as being sensitive to sexual-minority needs or desires.

Thank you so very much for accepting this letter in the positive vein it was meant and for understanding the need for consumer voice and direction in what we do. Your strength and understanding gives us hope for a better tomorrow.

This letter was reviewed and voted acceptance by the Mental Health Planning and Advisory Council at the June 11, 2008 meeting, held in Yakima, Washington.

Sincerely,

Catherine B. Nash, Chair
Mental Health Planning and Advisory Council

Rick Crozier, Vice-Chair
Mental Health Planning and Advisory Council

Program Synopsis by RSN

Chelan – Douglas

Total Funding: $98,387

$3,000 - NAMI – "Visions for Tomorrow" – training
$3,750 - NAMI – Family to Family – 25 family members to attend seminars
$2,000 - NAMI – Peer to Peer – will conduct peer to peer training
$7,500 - CIT for 20 new officers and follow up for 30 additional officers
$1,500 - Clubhouse Newsletter – postage for newsletter
$40,000 - Housing Subsidies to 86 individuals following hospitalization or incarceration
$30,000 - Medications to 111 non-Medicaid consumers
$10,637 - Consumer Trainings – WRAP, peer-to-peer, and 'other' trainings. (Includes travel to take peer-to-peer tests)

Clark County RSN

Total Funds - $370,727

$181,807 – Consumer Voices are Born will maintain a drop-in center for 700 consumers, a warm line, employment support services and assistance in acquiring social security benefits
$95,000 – NAMI will give services to 900 – 1000 consumers per year, train 40 law enforcement officers in CIT and conduct In Our Own Voice presentations.
$25,920 – Val Ogden Clubhouse (ICCD) will accept 3 non-Medicaid consumers daily
$50,000 – Wellness Project will provide psych services to 50 non-Medicaid consumers per month
$10,000 – Trainings for staff and consumers in integration of peer-support services and another on cross-cultural competencies
$8,000 – Consumer scholarships to attend trainings and conferences

King County

Total Funding: $1,712, 352

$360,732 – Emergency Telephone System will refer 60,000 callers per year with crisis intervention or to community-based services as needed
All Crisis services are paid and mandated by the State. No need to fund with FBG dollars

$1,035,484 - Children's Crisis Outreach Response will provide app. 600 families with outreach, stabilization, host-family placement and resource referral
All crisis services are paid and mandated by the State. No need to fund with FBG dollars

$2,500 – Tribal Youth Suicide Prevention will continue with plans developed for Tribes to prevent youth suicide

$313,636 – Geriatric Crisis Services will provide app. 220 older adults with out-of-facility services
All crisis services are paid and mandated by the State. No need to fund with FBG dollars

Gray's Harbor County RSN

$24,000 – Outreach and pre-service engagement of 30 older adult Tribal members
$9,445 – Increase support groups and locations for NAMI –WA Coast
$7,050 – Consumer Recovery and Resiliency conference for 30 – 40 consumers
$1,750 – 25 people to attend Trauma informed Care training through UW Psych Trauma Program
$3,900 – Training 20 staff in WRAP
How many consumers will be potentially aided with this training? What are the outcomes? Will this be true to the Program's fidelity?
$32,000 – Training 20 law enforcement persons in CIT
$6,500 – Flex funds for app. 10 adults in achieving goals, Sea-Mar provider
$7,800 – Flex funds for app. 12 adults to achieve goals, Roger Saux provider
$2,500 – Flex funds for app 25 – 50 children to achieve goals, Roger Saux provider
$7,800 – Flex funds for 12 adults to achieve goals, BHR provider
$2,500 – Flex funds for 25-50 children to achieve goals, BHR provider

Greater Columbia RSN – by County

Total funding for GCBH - $607,557

Asotin County
$25,110 – Adult WrapAround to serve 11 non-Medcaid
$3,000 – Child/Youth WrapAround to serve 2 non-Medcaid
Benton / Franklin County
$117,698 - parent partners to provide peer support to 120 families
Will this program be staffed with peer counselors that are being paid as professionals? If so, then why aren't these hours being billed to Medicaid for reimbursement? If these 120 families are non-Medicaid, then this should be specified in the contract to avoid confusion
$22,442 – youth partner to provide peer support to 60 youth
See above
Columbia County
$2,232 – 2 each 3-hour assessments for 18 non-Medicaid clients
$3,000 – 2 each Crisis trainings for law enforcement, nurses, EMTs
$ 3,000 - 2 each community outreach to older adults
$2,808 – community support to 24 non-Medicaid clients
$1,800 – therapy services to 4 non-Medicaid clients
Garfield County
$5,500 – Provide WrapAround to 4 non-Medicaid adults
$2,500 – Provide Child/Youth WrapAround to 2 non-Medicaid youth
Kittitas County
$12,849 - Provide peer counselor
Will this program be staffed with certified peer counselors that are being paid as professionals? If so, then why isn't Medicaid being billed? If these peer counselors are serving only non-Medicaid, this should be specified in the contract to avoid confusion.
$4,343 – Provide Consumer Advocate

See above, with the addendum that this consumer advocate should also be employed as a peer counselor for the above reasons, plus reduction of liability costs to the RSN
$6,038 – 20 consumers to receive training in resiliency and recovery
$6,500 – 5 consumers helped by supporting NAMI chapter

Klickitat County
$11,775 – Providing peer support counselor
See above responses to other peer counselor programs
$2,369 – providing consumer advocate
See above responses to other consumer advocate programs
$5,000 -15 clients trained in Resiliency and Recovery
$2,911 – provide stabilization services to non-Medicaid persons

Skamania County
$9,300 – Flex funds for meds and lab work for 5 – 15 non-Medicaid persons
$6,011 – psych services for 10 – 20 non-Medicaid persons

Walla Walla County
$12,000 – Clubhouse Support needed as temporary support during certification, 25 consumers to be served with 12 new consumers in attendance
If this is not a club house as defined in the Waiver or the State Plan, what can we do to help it become so and less dependant on FBG dollars in the future?
$40,209 – Stabilization services for 108 non-Medicaid clients

Whitman County
$5,000 – Clubhouse Support to non-Medicaid adults
$10,214 – case management for non-Medicaid Adults
$16,804 – In-School supports for non-Medicaid youth

Yakima County
$24,000 – access to participate in ICCD clubhouse
Please specify non-Medicaid in order to access FBG dollars
$33,376 – Employment of three peer counselors
Certified peer counselors are a reimbursable expense by Medicaid. This amount needs to be specified in the contract for non-Medicaid services if the FBG dollars are to be used. The number of non-Medicaid persons being worked with would greatly be appreciated in the statement of outcomes
$32,768 – employment of consumer advocate
Is this person a certified peer counselor? See above response for other consumer advocate programs
$29,000 – supported employment slots for 7 consumers
Is this program for Medicaid only or can any person access this supported employment program – regardless of meeting the access to care standards of the State?
$60,000 – COD residential treatment for 10 non-Medicaid consumers
$22,000 – Supporting 6 NAMI education trainings with a part-time Director and office space
$11,000 – Increasing Yakima Nation child access to services
$33,000 – Training 10 -15 staff in care of Yakima Nation for EBT's and best practices. Also purchasing clinical supervision for 3-4 unlicensed MSW staff
$6,000 – psychological testing of 3 consumers of the Yakima Nation

North Central RSN

$15,275 – Okanagon Behavioral Health psychiatrist to work with 35 older adults – 10% to OBH
$46,000 - 75 intensive care clients to be served – 30% to OBH
$21,168 – Pilot program: MH professional to be at health clinic two days per week and to see app. 150 clients
Innovative and great idea!
$10,000 – Transitional housing in Stevens County for up to 180 days for 4-8 adults at risk of being homeless
$40,000 – Medication management in Colville, Chewelah and Davenport for non-Medicaid clients
$4,000 - Working with Judicial system to reduce JRA convictions for est. 3 youth, MOU's will be developed with law enforcement
$32,000 – Equipment for telehealth system to serve 15 clients
The stipulation regarding equipment purchases of equipment is very specific: No more than $5000.00
This proposal should be denied and this amount spent by the RSN in other areas
$3,000 – Behavioral Health Conference scholarships for 6 clients
$4,500 – Funds to 3 Tribes for trainings and education
$15,695 – Health care service supports 24/7 for MH clients – est. 7 served

North Sound RSN

Total Funding - $983,871

$44,851 – Outreach to 60 non-Medicaid Adults upon discharge, Outreach specialist will procure safe, affordable housing
$5,000 – DD Skill Building Groups, 15 individuals
Is this a collaborative effort between agencies? If so – great job!
$37,871 – T.R.I.P Training Resources group in San Juan County parent partners advocating and working with 188 – 335 others for system navigation, training and education
Would it be possible to employ certified peer counselors in this program to help defer some of the cost onto the Waiver or will these parent partners be working only with non-Medicaid?
$30,000 – Access to Children's Mental Health Project for non-Medicaid children in school setting, 40 to be served, allows schools to contract directly with MHP on fee for service basis
Innovative and brilliant!!!
$30,888 – Rainbow Center will expand staff hours in an effort to become ICCD Clubhouse which will affect 60 – 70 people per day, funding is temporary
$33,309 – Gatekeeper provides case management, engagement and referral services to 75 – 80 older adults
$106,000 – Whatcom County Outreach Project will engage 139 – 158 consumers that are un-enrolled in acute care or Triage settings
$54,077 – Sea-Mar will provide integrated mental health and physical care to 60 non-Medicaid clients in a single location
$74,000 – Compass Health will provide case management to 65 consumers coming out of acute care settings that do not currently have Medicaid
$154,035 – Compass Health will provide assessment, community support services, eval, meds, to 251 consumers coming out of acute care and triage type settings
$81,840 – Tulalip Tribe access to services will provide holistic care for up to 500 consumers
$40,000 – Compass Health 28 children will be served in-home or in-school

$36,360 – Geriatric Depression Screening will be given to 50 older adults, in their homes, with up to five follow up visits following the assessment, funding will pay for .5 FTE to carry out the job
$18,000 – Outreach and group therapy for 30 children, expansion of service hours during school year
$36,640 – Northwest Youth Services will expand traditional programs with a comprehensive assessment and on-going counseling for 15 youth
$48,000 – Sun House Jail Diversion Project will provide housing, psychiatric support, case management and medication to 28 consumers released from jail or institution
$14,000 – Training clinicians in WrapAround services for eating disorders
Do we have any data based outcomes?
$15,000 – Follow-up to previous clinical trainings for WrapAround services
$35,000 – Stillaguamish Tribe will expand services for 9 – 16 non-Medicaid adults and children
$66,000 – 79 non-Medicaid high-end consumers will be provided short term assessment, case management and assistance with paperwork to apply for services
$33,000 – HOPE Options will provide in-home intervention to 30 older adults that have developed unstable housing

Peninsula RSN

$60,000 – Transition housing for re-integration of 9 non-Medicaid adults upon discharge from hospital or institution
$73,000 – Rental support for supported living programs for 26+ adults
$12,000 – Property damage claims payments for 10+ adults
$20,000 – Protective Payee for up app. 175 clients
$3,000 – Flex funds for meds, lab fee, for app. 3 non-Medicaid clients
$19,000 – Ombuds services for 40 adult and 4 children that are non-Medicaid individuals
Innovative and out- of –the-box thinking! Good job!!!
$36,000 – Providing parent voice for 50 adults and 19 children and helps to build natural supports
Are the parent partners in Bridges also peer support counselors? Is not, how much of this amount could be paid by Medicaid and be possibly more sustainable than the FBG?
$30,000 – Training fund for increasing peer counselors from 5 – 15 and EBP training for staff, Board members and network
$16,875 – Flex funds for grocery replenishment following a hospitalization for app. 600 families
$47,161 – Transportation home following discharge for app. 350 non-Medicaid clients

Pierce County

$135,000 - Pebbles in the Pond will pay personnel salaries and benefits, printing and operating expenses for its psychoeducation classes that serve 225 non-Medicaid persons yearly
Salary and benefits?

$30,600 – Greater Lakes will send 4 of its staff to be trained in DBT services. $5000 of this is attributed to lost revenue while staff is in training.
Although MHPAC fully supports EBP training, it would be very foolish to pay ANY entity for loss of revenue while staff is in training. This is not a reasonable request and Greater Lakes should be denied this $5000 portion of their request. It is the cost of doing business in a rapidly changing world.
Also needed from this training would be outcomes based on data. This is missing.

$68,172 – Greater Lakes will provide crisis mental health services to 297 youth incarcerated at Remann Hall with a .8 FTE
Remann Hall is a Title XIX DASA/ JRA program. Does this $68,000 apply to only non-Medicaid youth or is it paying for services that Medicaid does not re-reimburse? Also, crisis services and their payment should come from the State, not the FBG.
$95,644 – HEROS Geriatric Outreach – Gatekeeper type program utilizing peer counselors, therapists, psych services and cross agency referrals for older adults living in the community
Great out-of- the- box thinking!
$65,600 – TACID provides support groups, support group training for facilitators, employment assistance ($1,252), computer lab, provides community presentations, information and referral services and a lending library
$130,000 (for nine months) – A Common Voice provides and facilitates parent partners to run support groups, gather information, share information with the community and provide parent support in all environments such as school setting, JRA, mental health care agencies and will continue to be an advocate for parent and family voice, and access to care. $109,900 of the $130,000 is salary for the Director and the Assistant Director
Parent partners are needed in every RSN, but this program would be greatly enhanced with the addition of certified peer counselors to help shelter its profitability and reliability of financing through Medicaid billable hours. Also needed for continued FBG funding are measurable outcomes, especially consumer self-satisfaction reports.
Salary payments?
$41,200 - Pierce College Supported Education Program will pay a coordinator / class facilitator to provide an education program to support and prepare consumers for postsecondary / continued education and will assist in planning future vocational/ educational goals
Salary payment?
$185,000 – Rose House (a clubhouse) will develop rehab plans for 30 consumers, provide at least two trainings per month and in the community on recovery model and WRAP planning, develop a community Access resource center, provide bus training to app. 30 individuals and provide 10 non-Medicaid person with bus passes. It will also provide employment supports to at least 15 non-Medicaid consumers and planning for educational goals to 10 non-Medicaid consumers
Is the FBG paying for all of the Rose House expenses or is this amount just for non-Medicaid? At $185,000 for 15 non-Medicaid to receive employment supports makes this a very expensive program.
$0 – Kwawachee Counseling Center will shifts its focus from domestic violence to outreach and suicide prevention
Although the Center talked about continued funding, no mention of dollar amounts appeared in their narrative, nor outcomes, nor criteria / goals.

Southwest RSN

$78,592 – Two full-time co-occurring specialists at MH units. Both will jointly staff clients at two local substance abuse centers. Continuity Care Review (CCR) Team will link between substance abuse and MH systems of care.
$2,500 – Staff training for 40 staff in resiliency and recovery
Reasonable outcomes should be stated in the contract. How will this training impact the consumer? What will the staff do with the information they have gained?
$9,720 – 15 non-Medicaid youth will receive co-occurring treatment.
$0 – Collaboration with Tribes in integrated planning for co-occurring treatment.
No mention of dollar amounts found.

Spokane County

Total Funding - $413,150

$49,300 – Funding for SMH for 187 non-Medicaid consumers to attend Evergreen Club
Measurable outcomes and data are needed by the Council.

$181,577 – Integrated Co-Occurring Services of SMH will serve 535 non-Medicaid clients with community services for co-occurring and mental health disorders
The ICOS program was very generous in agreeing to take the contract from REM last year. However, attached to the Council's letter are two letters referring to that facility failing to achieve the DASA certification needed to be a qualified contractor for co-occurring disease in this State. Although this portion should be denied from this facility until they reach certified status, the RSN should be encouraged to search out a different contractor that specializes in COD work and is DASA certified

$104,550 - Homeless Outreach Team of SMH will provide increase access to 741 urban community- based homeless non-Medicaid clients
$17,000 - Camas Path will provide one training a year to 130 staff for the purpose of recruiting MHP's and gateway professionals in working with the Kallispell tribe
What are the measurable outcomes of this training?

$22,423 – Spokane Neighborhood Action Plan will provide rural community-based services for non-Medicaid consumers to improve access to care in rural and remote areas with housing assistance. Snap also provides family development coaching, case management and support services to the homeless in rural areas.
$38,300 – Supported Education Enhancing Rehabilitation will provide and expand continuing secondary education and employment services to 130 non-Medicaid clients

Timberlands

$90,178 total funds, $12,000 supplementary funds requested

$5,800 – Flex funds to clubhouse for supported employment/education and housing stability
$8,300 – Psych evals, medication management and meds for 25 adult non-Medicaid clients
$2,400 – increasing activities for two youth programs, 20 clients served
$4,320 – Geriatric outreach and MH counseling
$3,000 – Internal training of 40 – 80 clinical staff
$16,150 – 12 non-Medicaid co-occurring clients will receive services
$13,320 – Promising practice for PTSD clients (7 youth and 7 adult) – Equine Assisted Therapy
$7,656 – Hiring a peer counselor for 14.5 hours per week
$8,428 – outreach for 28 older adults per month
$2,376 – Support of Alzheimer care-giver support group and facilitator
$4,928 – flex funds for meds, housing, food, hygiene for 50 clients per year
$4,500 – Collaborative planning with Tribe to identify challenges and opportunities: travel, dual diagnosis, and RSN legal relation issues
$5,000 – Operations and equipment support for Club house
$2,000 – Flex funds for meds, housing, transportation, food, utilities and hygiene for app. 20 clients

$2,000 – Gatekeeper program to serve app.5 clients
Supplemental:
$3,000 – Additional funds for Tribal Collaboration
$9,000 – Additional funds to lengthen Aquine Assisted Therapy Program

Thurston – Mason

$36,000 – Free mental health clinic to serve 30 – 50 non-Medicaid individuals per year
Innovative and creative. Great idea!!
$30,000 – Facilitate process to establish an EBP for children of the Skokomish Tribe
$10,000 – service development for non-traditional, non-Medicaid services for 6 local tribes
$84,000 – Capital Clubhouse to serve 30 non-Medicaid individuals, will include supported employment work placements for 10
Clarification needed. Are the ten work placements Medicaid or non-Medicaid?
$30,000 – Flex funds for 30 – 40 non-Medicaid persons needing meds, housing, utilities, and most persons are recently released from jail or hospital
$10,000 – Supporting a peer support person that will also act as a family advocate. Between 25 and 30 families served
Peer support is a Medicaid reimbursable expense. This amount needs to be ear-marked for non-Medicaid to fall within the Council's guidelines.
$61,335 – Primary care / mental health integration by contracting with a behavioral consultant (one FTE) to provide mental health consultation to primary physicians, Services for adults and older adults

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

May 5, 2008

David Panken, CEO
Spokane Mental Health
107 South Division
Spokane, Washington 99202-1586

RE: AGENCY NUMBER 32 0122 00

Dear Mr. Panken:

The Division of Alcohol and Substance Abuse (DASA) conducted an on-site technical assistance survey of Spokane Mental Health on March 21, 2008. The survey was conducted in accordance with DASA's May 20, 2005 letter granting exemptions to the agency for co-occurring services, and the March 4, 2008 notice extending the expiration date of the exemption. The survey was authorized by Revised Code of Washington 70.96A and Washington Administrative Code 388-805, and its purpose was to determine compliance with applicable requirements.

The survey consisted of interviews with selected staff, and reviews of relevant personnel files and samples of patient/client records. The agency chose ten patient records from the Integrated Co-Occurring Services (ICOS) program, and five from the Adult Outpatient Program (AOP) for review. These numbers represent approximately 5% and 10% of the total caseloads of the programs, respectively.

A closing summary was held at the end of the survey to review and discuss our findings.

The numbering system below lists the conditions in the exemption letter and describes related deficiencies..

1. A chemical dependency professional (CDP) who meets the requirements of WAC 246-811 must participate in the substance abuse diagnosis, treatment, and discharge for each patient diagnosed with a co-occurring disorder under the terms of a state or county contract for those services.

   Discussion: Interviews with staff and patient record reviews found that patients whose chemical dependency is in remission are diagnosed as such by professional staff who do not hold a CDP credential. Whether or not the patient is in remission, a CDP must be involved in the diagnosis because it is the diagnosis that determines remission status.

   AOP files documented CDP involvement in the treatment process, but only three of five patient records documented CDP involvement in the diagnosis.

ICOS files documented CDP involvement in the diagnosis, but not in the treatment process.

Files chosen by the agency did not include discharged patients, so I did not determine whether or not ICOS discharges meet the terms of the DASA exemption.

The clinical entries of CDP Trainees who signed treatment documents were not co-authenticated by a CDP. In addition, there was no documentation until March 14, 2008 that CDP Trainees were supervised by an Approved Supervisor.

This condition of the exemption was not met.

2. Spokane Mental Health (SMH) will furnish DASA copies of all contract compliance and certification/licensing reports concerning the SMH co-occurring disorders program for the duration of this exemption within 30 days of receipt of the required reports. The copies of the reports shall be forwarded to:

    Provider Request Manager
    Certification Section
    DSHS/DASA
    Post Office Box 45330
    Olympia, Washington 98504-5330

Discussion: SMH staff have not been meeting this condition of exemption, explaining that they did not think it necessary if contract compliance and certification/licensing bodies did not specifically survey the co-occurring programs.

Technical assistance was provided regarding this condition. The agency provided copies of the most recent reports, and agreed to send them as required in the future.

This condition of the exemption was not met.

3. DASA TARGET data on all services delivered under the contract will be electronically submitted at least once every quarter by the tenth working day of the month following the end of the quarter.

Since SMH does not provide DASA-contracted or county-contracted co-occurring services, this condition does not apply.

4. This exemption applies only to those patients receiving contracted co-occurring disorder services that are diagnosed with a mental illness and substance abuse, as defined by SMH. Patients receiving non-contracted substance abuse treatment services provided by SMH and certified by DASA must continue to meet all applicable requirements of WAC 388-805.

This condition is met. The agency does not provide substance abuse services to patients other than those with co-occurring mental health diagnoses.

5. Co-occurring treatment information must be protected under the confidentiality regulations governing Alcohol and Drug Abuse Patient Records of Chapter 42, Code of Federal Regulations (CFR), Part 2.

Discussion: The release used at SMH for co-occurring patients does not meet the following 42 CFR Part 2 standards.

- The nature of the information to be released must be as limited as possible to meet patient needs, and must be specific. "Any information pertaining to my alcohol or drug treatment" is insufficient. The back of the release form restates similar language.

- A patient may verbally revoke a release under 42 CFR Part 2. The agency's release requires written revocation.

- Prohibition of redisclosure applies in every case with co-occurring patients. When the agency releases information about a patient on the basis of a release, or due to one of the exceptions, it must follow up with a written notice that the information released cannot be redisclosed without the patient's written authorization.

  I recommend as a model Form 2A, Sample Notice Prohibiting Redisclosure, in The Legal Action Center's Confidentiality and Communication: A Guide to Federal Confidentiality Law and HIPPA, 2006 Edition.

  Additionally, the SMH Notice of Privacy Practices contains a paragraph on 42 CFR Part 2 confidentiality elements, but they contradict some of the other passages in the same packet. I recommend you use as a model Form 7A, Sample Patient Notice, in the book noted above.

  This condition of the exemption was not met.

By June 6, 2008, please send me a corrective action plan (CAP) with an implementation schedule for items 1, 2, and 5 listed in this report. In your CAP describe specific actions Spokane Mental Health will implement to ensure the conditions of the exemption are met and maintained. Include dates by when the corrective actions will be completed. A Corrective Action Plan Review (CAPR) will be scheduled to review the implementation of the corrections.

Provided DASA receives an acceptable CAP by June 6, 2008, the current exemption will be extended for three months to allow time for the CAPR to be conducted. The results of the CAPR will determine whether or not DASA will renew the exemption beyond the extension.

Please contact me if you have any questions, or if you need technical assistance regarding the survey or the enclosed report, a copy of any regulation cited, or additional time to submit your plan.

Thank you and your staff for the hospitality, open reception, and cooperation that you provided throughout my visit.

Sincerely,

Mary Testa - Smith

Mary Testa-Smith, MS, CCDCIII
Certification Specialist
Division of Alcohol and Substance Abuse
1212 North Washington, Suite 207
Spokane, Washington 99203
Phone: (509) 329-5814; Fax: (509) 329-3728
E-mail: testams@dshs.wa.gov
www.dshs.wa.gov/dasa

cc: Cyndi Beemer, DASA Region 1 Administrator (by e-mail)
Julián Gonzales, DASA Certification Section Field Services Lead (by e-mail)
Dan Finn, Spokane County Alcohol and Drug Coordinator (by e-mail)

DASA

CERTIFICATION SECTION

WORK MEMO TO AGENCY FILE

AGENCY NAME: **SPOKANE MENTAL HEALTH**

AGENCY NUMBER: **32 0122 00**

DATE: 10/25/07

METHOD OF CONTACT: Meeting

NOTES: I met with SMH staff today to try to determine compliance with our regulations, specifically with the exemptions granted by David Curts in a letter dated 5/20/05. Participating SMH staff included Tom Anderson, Director of Quality Improvement; Marilyn Wilson, Director of Clinical Services; Jane Schollmeyer (CP00005230), Director of Adult Outpatient Services (AOP); Susie Stapleton, Director of Integrated Co-Occurring Services (ICOS); and two others whose names I did not record.

Agency staff completed an Administrator Change Form. The new administrator is David Panken, CEO. I am mailing the hard copy of the completed form to Lacey tomorrow for processing.

The numbering below reflects the numbering used in the 5/20/05 exemption letter:

1. The agency has two Co-Occurring programs: AOP and ICOS programs. These programs serve approximately 200 current patients. There is a CDP at the head of AOP, and a CDP in ICOS as line staff. The main staffing issue we discussed was that the CDP at ICOS is not yet qualified to be the Approved Supervisor of the ICOS CDPT, and the AOD is completely separate so Jane is not really available to do the Approved Supervision. Several solutions were discussed to maintain patient safety and the integrity of the CDPT training process.

   Recommend: Cert follow-up prior to the renewal of the exemption, which expires 1/22/08.

2. The exemption letter requires SMH to submit all Mental Health and county contract review reports. Since these entities review the entire SMH program, not just the co-occurring elements, SMH staff were under the impression that they did not need to send copies of the reports to DASA. I advised them that they should, and they agreed to comply.

   Recommend: Cert follow-up prior to the renewal of the exemption, and reevaluate the requirement.

3. The exemption letter requires SMH to enter TARGET data quarterly. They have never been issued a TARGET modem, certificates, or training, and thought this requirement did not refer to them since they do not have a DASA or county contract for CD. But it's required by our letter. I encouraged SMH staff to write a letter to Dennis requesting an exemption to this requirement. There's no point having a requirement that they do not need to meet written into

the letter. If SMH actually does need to meet this requirement, I'm not sure they'll opt to keep their DASA certification.

Recommend: Evaluate the forthcoming request for an exemption to this requirement. If the decision is to grant that exemption, this requirement can be deleted in the next letter. If they must be involved in TARGET, they will need technical assistance, hardware, and training from DASA, and they will need to hire someone to input the data. I recommend granting the exemption from TARGET, but understand that this is outside my area of expertise, and might not be an appropriate recommendation. SMH staff told me that they think it would be administratively burdensome to have to do TARGET, since they'd have to hire a person to input the data, and because the TARGET intake would require CDP time that is not available.

4. SMH does not provide any non-contracted CD services.

   Recommend: No recommendations

5. SMH staff say they understand 42 CFR, its implications for SMH Co-Occurring Disorders services, and its relationship to HIPAA. I encouraged them to get the Legal Action Center book. I offered technical assistance on confidentiality if they ever want it. I did not detect any interest.

   Recommend: Cert follow-up actual practices prior to the renewal of the exemption letter.

PRINTED NAME	SIGNATURE
Mary Testa-Smith, DASA Certification Specialist	Submitted by e-mail

cc: Cyndi Beemer, DASA Region 1 Administrator (by e-mail)
Dennis Malmer, Certification Section Supervisor (by e-mail)
Julián Gonzales, DASA Certification Section Field Services Manager (by e-mail)
Bob Geissinger, DASA Certification Section Provider Request Mgr (by e-mail)
Dan Finn, Spokane County Alcohol and Drug Coordinator (by e-mail)

Washington

Appendix A (Optional)

OPTIONAL- Applicants may use this page to attach any additional documentation they wish to support or clarify their application. If there are multiple files, you must Zip or otherwise merge them into one file.